

**District of Columbia**  
**Department of Health**  
**Medical Assistance Administration**

**Provider Billing Manual**  
**Vision Care**



**Release 1**  
**May 2002**

Initial the *Incorporated By* column to indicate who replaced the pages in the binder.

Release Number	Revised Date	Incorporated By
1	05/30/03	

Make the following revisions to your Manual Documentation and then file this index before the Table of Contents to keep a record of all revisions.

Revision Reference				
Section	Remove Page	Insert Page	Revised Page(s)	Description of Change
Billing Manual Cover Page	N/A	Not numbered	New	▪ Added standard Billing Manual cover page.
Revision Index	N/A	2	New	▪ Insert Revision Index page, Revised Date of 05/30/03.
Table of Contents	N/A	3-6	New	▪ Added Table of Contents.
Section 8.8	50	50	50	▪ Added paragraph requesting provider name, tax id, provider Medicaid number, and name of person making call.
Section 13.5	68-69	68-69	68-69	<ul style="list-style-type: none"> <li>▪ Removed references to submitting attachments for Option I, Option II</li> <li>▪ Added instructions for billing frames, lenses, and fittings using standard HCPCS codes.</li> </ul>
Section 13.6	72	72	72	<ul style="list-style-type: none"> <li>▪ Removed references to submitting attachments for Option I, Option II</li> <li>▪ Added instructions for billing frames, lenses, and fittings using standard HCPCS codes.</li> </ul>
Section 13.8	85	85	85	▪ Removed reference to Option I and Option II for Block 20.

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DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE ADMINISTRATION

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## **1.0 GENERAL INFORMATION**

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This section of the District of Columbia Medicaid Provider Manual presents a general overview of the purpose and organization of the manual. Information about the maintenance and distribution of the manual is also included.

### **1.1 Purpose of the Manual**

This manual's purpose is to document the policy and procedures for healthcare providers who participate in the District of Columbia (DC) Medicaid Program. The procedures include specific instructions to file claims for reimbursement and document medical records.

### **1.2 Policy**

Providers are responsible for adhering to the requirements set forth in this manual. The requirements are generated from Federal regulations and the interpretation of these regulations specific to the District and its' policy.

### **1.3 Maintenance**

ACS will maintain this manual with information supplied by Medical Assistance Administration (MAA). When a revision occurs, replacement pages for the manual will be supplied to the providers by ACS. It is the responsibility of the DC Medicaid provider to review the revisions to the manual and ensure that the policies and procedures are followed.

### **1.4 Distribution**

This manual will be distributed to providers who participate in the DC Medicaid Program, via the United States Postal Service. Each manual update will be transmitted with a numbered transmittal and an updated REVISION INDEX to track all updates to the manual.

## **1.5 Organization**

This manual is organized into 13 sections. When a revision occurs to any part of this manual, a revised page will be issued to providers and should be inserted in the proper location. The outdated material should be discarded. Revised pages will carry a revision date in the lower right corner of the page. A Revision Index has been included in this manual following the Table of Contents. Each time a revision to the manual is issued, an updated Revision Index page(s) should replace the one(s) currently in your manual so that you have an accurate record of revisions made to the manual.

Other information that might be helpful when using this manual include:

- “His” refers to both genders throughout the manual.
- Terms used throughout this manual are defined in Section 3.0, Glossary.
- Addresses and telephone numbers referenced throughout this manual are included in Appendix A.

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## **2.0 INTRODUCTION**

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The following subsections provide information regarding the DC Medicaid Program.

### **2.1 District of Columbia Medicaid Program**

The DC Medicaid Program is a Federally assisted, District-operated program designed to provide comprehensive medical care and services of a high quality at public expense to all eligible residents of the District of Columbia. The DC Medicaid Program, as mandated by the United States Congress, permits eligible individuals the freedom of choice in the selection of a provider of healthcare services who has agreed to the conditions of participation by applying and being accepted as a provider of services.

### **2.2 Legal Authority**

Medicaid is authorized by Title XIX of the Social Security Act, 42 U.S.C. 1396, *et seq.* District participation is authorized by enabling legislation P.L. 90-227, 12/27/67.

### **2.3 Administration**

The Department of Health (DOH) is the District of Columbia agency responsible for administering the DC Medicaid Program. MAA, is the bureau within DOH which administers the program.

### **2.4 Covered Services**

The following services, when rendered by eligible providers to eligible recipients, are covered by DC Medicaid:

- Dental (individuals under 21 years of age)
- Early and Periodic Screening, Diagnosis, and Treatment
- Home Health Care
- Emergency Services
- Inpatient Hospital

- Intermediate Care Nursing Facility (ICF)
- ICF/MR
- Laboratory and X-Ray
- MRDDA
- Managed Care
- Medical Equipment, Supplies, Prosthesis, Orthosis, and Appliances
- Medical Clinic (hospital and free-standing)
- Medical Transportation Service
- Medical Day Treatment
- Optometry
- Organ Transplant
- Out-of-District Services
- Osteopathy
- Personal Care
- Pharmacy
- Podiatry
- Physician
- Skilled Care Nursing Facility (SNF)

MAA pays for covered services rendered out-of-District to eligible District recipients, if any of the following circumstances exist:

- The services were rendered by an enrolled provider in the DC Medicaid Program.
- The recipient requires emergency medical care while temporarily away from his home.
- The recipient would be risking his health if he waited for the service until he returned home.
- Returning back to the District would endanger the recipient's health.
- Whenever it is general practice for recipients in an area of the District to use medical resources in a neighboring state.
- MAA decides, based on the attending physician's advice, that the recipient has better access to the type of care he needs in another state.

More detailed information regarding the program, its policies and regulations is available from MAA.

### **2.5 Non-Covered Services**

Based on the policies established by MAA, certain services are not covered by the DC Medicaid Program:

- Patient convenience items
- Meals for family members
- Cosmetic surgery directed primarily at improvement of appearance
- Experimental procedures
- Items or services which are furnished gratuitously, without regard to the individual's ability to pay and without expectation of payment from any source, i.e. free health screenings

This list is only an example of the services not covered and should not be considered a complete list.

### **2.6 Inquiries**

To receive information about the District of Columbia Medicaid Program, contact the DC Medicaid Fiscal Agent, ACS. Addresses and telephone numbers are included in Appendix A.

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## 3.0 GLOSSARY

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The following terms are used throughout this manual. The definition relates to the term in the DC Medicaid Program:

ACS	Affiliated Computer Services – Fiscal Agent for the DC Medicaid Program
ANSI	The American National Standards Institute
Approved	A term that describes a claim that will be or has been paid.
Automated Client Eligibility Determination System (ACEDS)	The combined eligibility determination system providing integrated automated support for several District of Columbia programs, including Medicaid.
BED	Bureau of Eligibility Determination
Buy-In	The process whereby MAA authorizes payments of the monthly premiums for Medicare coverage.

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMS	Centers for Medicaid and Medicare Services
CPT	Current Procedural Terminology code
Claim	A request for reimbursement of services that have been rendered.
Claim Type	A classification of claim origin or type of service provided to a recipient.
Claim Status	The determined status of a claim: approved, denied or pended.
Commission on Health Care Finance	The former name of the local District agency which administers the Medicaid Program and performs other necessary Medicaid functions. New designation within the Department of Health for this agency is <i>Medical Assistance Administration (MAA)</i> .
Covered Services	All services which providers enrolled in the DC Medicaid Program are either required to provide, or are required to arrange to have provided to eligible recipients.
Crossover	The process by which the Medicare Intermediaries and Medicare Carriers supply Medicaid with the deductible and co-insurance amounts to be paid by Medicaid.
DCID	District of Columbia eight-digit recipient ID number
DCMMIS	District of Columbia Medicaid Management

	Information System
DHR	Department of Human Resources
DHS	Department of Human Services
DHHS	The U.S. Department of Health and Human Services
DOH	Department of Health
DX	Diagnosis Code
District	The District of Columbia
EOMB	Explanation of Medical Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment. A Medicaid initiative that provides preventative healthcare services for children.
EQRO	The External Quality Review Organization (see also PSRO) hired by the District to conduct independent reviews, audits and quality assurance functions for the Medicaid program.
EVS	Eligibility Verification System. A system to provide verification of recipient eligibility through telephone inquiry by the provider, using the DCID number.
Emergency	Emergency medical care shall mean the sudden unexpected onset of a condition requiring medical or surgical care that may result in permanent physical injury or a threat to life if care is not secured immediately after the onset of the condition or as soon thereafter.

Enrollment	The initial process by which new enrollees apply for managed care.
HCFA	Health Care Financing Administration
HCFA 1500	Claim form currently mandated by CMS, formerly known as HCFA, for submission of practitioner and supplier services
HIM	Health Insurance Manual
HMO	Health Maintenance Organization
ICD-CM	International Classification of Diseases – Clinical Modification
Involuntary Disenrollment	The involuntary termination of an enrollee from membership in the caseload of a managed care fee-for-service provider by the DC Medicaid program under conditions permitted by District and federal regulations.
MAC	Maximum Allowable Cost
Managed Care	Program to improve access to primary and preventive services where eligible recipients shall be required to select a primary care provider who will be responsible for coordinating the recipient's care. Payment for services shall be on a capitated basis

	for prepaid plans and a fee-for-services basis for primary care physicians in private practice.
Medicaid	The District of Columbia Medical Assistance program, provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.
Medicaid Benefits Package	All health services to which recipients are entitled under the District of Columbia Medicaid Program, except service in a skilled nursing facility, an institution for mental diseases, and other services specifically excluded in the contract.
Medical Assistance Administration (MAA)	The local district agency that administers the Medicaid Program and performs other necessary Medicaid functions.
Medically Necessary	Description of a medical service or supply for the prevention, diagnosis, or treatment which is (1) consistent with illness, injury, or condition of the enrollee; (2) in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered.
NDC	National Drug Code
Non-Compensable Item	Any service a provider supplies for which there is no provision for payment under Medicaid regulations.
Open Enrollment Period	The 30-day period following the date the recipient is certified or re-certified for the District's Medicaid

	<p>Program. During this period, a recipient eligible to be covered under the managed care program may select a provider without restriction.</p>
Ophthalmic Dispensing Services	<p>The design, verification, and delivery to the intended wearer of lenses, frames, and other specifically fabricated optical devices as prescribed by an optometrist or ophthalmologist.</p>
PCA	<p>Personal Care Aide. Provides health care services to homebound District of Columbia residents. Must meet certification requirements.</p>
PSRO	<p>Professional Standards Review Organization. An organization that operates review systems to determine whether services are medically necessary, provided appropriately, carried out on a timely basis, and meeting professional standards.</p>
Parent	<p>A child's natural parent or legal guardian.</p>
Prepayment Review	<p>Determination of the medical necessity of a service or item before payment is made to the provider. Prepayment review is performed after the service or item is provided and involves an examination of an invoice and related material, when appropriate. This should not be confused with prior authorization.</p>
Prescription (Vision)	<p>The written direction from a licensed ophthalmologist or optometrist for therapeutic or corrective lenses and consists of the refractive power and, when necessary, the vertex distance, the cylinder axis, and prism.</p>

Primary Care Physician or Clinic	A Medicaid participating physician or clinic who/which practices as a general practitioner, family practitioner, internist, pediatrician, or obstetrician/gynecologist and who/which has entered into an agreement with the District of Columbia Medicaid Program to act as a managed care provider.
Prior Authorization	The approval of a service before it is provided.
Provider	A person, business, or facility currently licensed under the law of any state and enrolled in Medicaid to practice medicine, osteopathy, dentistry, podiatry, optometry, or to provide other Medicaid-approved medical services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services.
RA	Remittance Advice. A document sent to providers to report the status of submitted claims - paid, denied and pended from ACS.
RTP	Return to Provider
RTP Letter	A letter that accompanies a rejected claim that is sent to providers with an explanation.
Rejected	A term that describes a claim that has not met processing requirements.
Service Area	The area within the city limits of the District of Columbia.

Specialist	An enrolled Medicaid physician whose practice is limited to a particular area of medicine including one who, by virtue of advance training, is certified by a specialty board.
Spend-Down	Occurs when an individual or family is ineligible for Medicaid benefits due to excess income but can receive Medicaid benefits by incurring medical expenses in the amount of the excess income.
State Plan	The State Plan of Medical Assistance which describes the eligibility criteria, services covered, payment methodology and/or rates and any limitations approved by the Health Care Financing Administration for coverage under the District of Columbia's Medicaid Program.
TANF	The categorical eligibility designation for individuals who are eligible for Medicaid by virtue of the fact that they are eligible for cash assistance from the Temporary Assistance for Needy Families (TANF) program.
TCN	The unique transaction control number that is assigned to each claim for identification
Third-Party Liability	Medical insurance, other coverage, or sources which have primary responsibility for payment of health care services on behalf of a Medicaid-eligible recipient.
Urgent Care Services	Care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment and/or a hospital

environment

Vendor

A provider who usually sells an item such as durable medical equipment, medical supplies, or eyewear.

Void

A claim which has been paid and is later refunded because the original reimbursement was made for an erroneous provider or recipient identification number.

Waiver

A situation where CMS allows the District to provide services that are outside the scope of the approved State Plan services, in non-traditional settings, and/or to recipients not generally covered by Medicaid.

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## **4.0 PROVIDER PARTICIPATION INFORMATION**

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This section of the manual provides information regarding enrollment of providers to participate in the DC Medicaid Program.

### **4.1 Participating Provider**

A participating provider is a person who has an executed provider agreement with MAA.

In order to participate in the DC Medicaid Program, providers must adhere to the guidelines established by MAA and outlined in their individual provider agreements. At a minimum, providers must adhere to the following requirements:

- All conditions specified in the provider agreement, signed by the provider and representative of MAA
- All policies and procedures established by MAA in regard to practice and procedures and in compliance with Title XIX
- Notification to MAA of any change in the information supplied to enroll in the program, i.e. address, group affiliations, additional licenses acquired, etc.
- Assurance of freedom of choice to all recipients of health care services.

### **4.2 Provider Types**

The following types of providers qualify for Medicaid program enrollment consideration:

• Adult Day Care	• Home Health Agency
• Alcohol and Substance Abuse Clinic	• Hospice
• Ambulance Transportation	• ICF/MR
• Ambulatory Surgery Center	• Independent Lab
• Assisted Living	• LTAC Hospital
• Audiologist	• Mental Health Clinic

## 4.0 PROVIDER PARTICIPATION INFORMATION

• Birthing Center	• Nurse Practitioner
• Case Manager	• Nursing Facility
• Community Residential Facility	• Optician
• Day Treatment	• Optometrist
• DC Schools	• Other Medical Transportation
• Dental Clinic	• Pharmacy
• Dentist	• Physician DO
• DHS Dental Clinics	• Physician MD
• DME Provider	• Podiatrist
• Emergency Access Hospital	• Private Clinic
• Family Planning Clinic	• Psychiatric Hospital Private
• Federal Quality Health Center	• Psychiatric Hospital Public
• Freestanding Radiology	• Public Health Center
• General Hospital	• Radiation Therapy Center
• Hearing Aid Dispenser	• Rehabilitation Centers
• Hemodialysis Center - Freestanding	• Residential Treatment Centers
• HMO	• Screening Clinics
• Home Community Based Waiver	• Speech/Hearing Clinic

### 4.3 Eligibility Requirements

Providers shall meet the following certification requirements in order to be considered for participation in the DC Medicaid Program. Requirements differ based on provider type and/or location as noted below:

#### 4.3.1 District Providers

Licensed, registered, and/or certified providers in the District of Columbia and those residents in the Greater Washington Metropolitan Area (must use District of Columbia hospitals) are eligible to request consideration for participation in DC Medicaid.

### **4.3.2 Out-of-District Providers**

Licensed, registered, and/or certified providers who are enrolled in their respective state Medicaid programs are eligible to request consideration for participation in the DC Medicaid Program. These providers are subject to the regulations of the DC Medicaid Program and must meet all requirements of MAA.

### **4.3.3 Group Practice Providers**

Licensed, registered, and/or certified providers who have an occupancy permit (where applicable), are eligible to request consideration for participation in DC Medicaid through a group practice.

### **4.3.4 Health Facilities**

Licensed and certified health facilities are eligible to request consideration for participation in DC Medicaid. In the case of new facilities or new services, acquisition of a certificate of need from the State Planning and Development Agency (SHPDA) may also be required.

## **4.4 Application Procedures**

In order to become a DC Medicaid provider of service, a practitioner must request an enrollment form and a participation agreement from ACS. The address is included in Appendix A.

Telephone requests may be accepted by calling the ACS Provider Enrollment number listed in Appendix A.

Completed enrollment forms and signed provider agreements should be returned to the same address.

## **4.5 Approval**

ACS will notify applicants in writing whether or not they have been approved for participation in the DC Medicaid Program. The notification will include the unique number assigned to the provider by ACS. After the provider has been approved, ACS will distribute billing instructions and forms as necessary to the provider.

A provider who has been approved is eligible to be reimbursed only for services furnished on or after the effective date of the Provider Agreement and only for those services he is eligible to render subject

## **4.0 PROVIDER PARTICIPATION INFORMATION**

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to limitations in this section and in Section 12.0. The effective date determined by ACS will not be earlier than the first day of the second month, prior to the month in which the application was received. For example, a provider application received on April 15, 2002, could have an effective date of February 1, 2002. Each provider is assigned a nine-digit provider number to be used when communicating with the program and submitting claims.

### **4.6 Special Requirements for the Group Practice**

When a group practice has been approved for participation, the group will be assigned a provider number. Payment for services rendered by all members of the group will be made under this number. Every member in the group must also be enrolled in DC Medicaid and have signed an individual Provider Agreement as well. A provider number will also be assigned to each member in the group to indicate which member is rendering the service.

To add a new member to the group, an enrollment package must be obtained, completed and submitted to ACS.

### **4.7 Special Requirements for Health Maintenance Organizations**

In addition to executing a provider application, an HMO or other pre-paid health plan must sign an agreement, renewed annually, with the DC Medicaid Program in order to enroll Medicaid recipients.

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## **5.0 REGULATIONS**

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The regulations that govern the DC Medicaid Program are contained in Title XIX of the Social Security Act, 42 U.S.C. 1396, (*et seq.*) and authorized by enabling legislation P.L. 90-227, 12/27/67. The Department of Health is the District's agency responsible for administering the Medicaid Program. MAA is the bureau within the Department, which administers the program.

An overview of the regulations governing provider activities follows.

### **5.1 Recipient Freedom of Choice of Providers**

A recipient may obtain services from any institution, agency, pharmacy, medical, professional, or medical organization that has an agreement with MAA to provide those services. Therefore, there will be no direct or indirect referral arrangements between physicians and other providers of health care services, which might interfere with a recipient's freedom of choice. This is not intended to prohibit a physician from recommending the services of another provider, but does prohibit automatic referrals between providers, which could interfere with the recipient's freedom of choice.

### **5.2 Discrimination**

Federal and District of Columbia regulations require that all programs receiving Federal and local assistance comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 and the regulations at 45 CFR Parts 80 and 84. MAA ensures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or handicap.

### **5.3 Interrelationship of Providers**

Providers are prohibited from referring or soliciting recipients directly or indirectly to other providers for financial consideration. Providers are also prohibited from soliciting, receiving or offering kickbacks; payments, gifts, bribes, or rebates for purchasing; leasing, ordering, arranging for, recommending purchasing, leasing; ordering for goods, facilities, or items for

which payment is made through the DC Medicaid Program. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services such as laboratory and X-Ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.

## **5.4 Record Keeping**

Providers shall retain for a minimum of six years (unless otherwise specified), medical and fiscal records that fully disclose the nature and extent of the services rendered to recipients. These records must meet all of the criteria established. Providers shall make such records readily available for review and copying by District and Federal officials or their duly authorized agents. The term "readily available" means that the records must be made available at the provider's place of business. If it is impractical to review records at the provider's place of business, upon written request, the provider must forward without charge, the original records or facsimiles. Records supporting those cost reports shall be retained until MAA advises the provider that his audit for that year is final. If MAA terminates an agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements stated in this manual.

### **5.4.1 Medical Records**

Providers who have examined, diagnosed, and treated a patient, shall maintain individual recipient records that:

- Are legible throughout and written at the time services are rendered
- Identify the recipient on every page
- Are signed and dated by the responsible licensed provider. Stamped signatures will not be accepted. All care by ancillary personnel must be countersigned by the responsible licensed provider. Any alterations to the record must be signed and dated
- Contain a preliminary working diagnosis as well as final diagnosis, including elements of a history and physical examination upon which the diagnosis is based
- Document in compliance with the service definitions and descriptions found in Physicians' Current Procedural Terminology (CPT)

- Reflect treatments as well as the treatment plan
- List quantities and dosages of drugs or supplies prescribed as part of the treatment and well being of the patient
- Indicate the progress of the recipient at every visit, the change of the diagnosis, the change of treatment, and the response to the treatment
- Contain summaries of all referrals, hospitalizations, and reports of operative procedures and excised tissues
- Contain the results of all diagnostic tests and reports of all consultations
- Reflect the disposition of the case.

#### **5.4.2 Fiscal Records**

Providers shall retain for a minimum of six years, all fiscal records relating to services rendered DC Medicaid recipients. This may include, but is not necessarily limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are Medicaid eligible, and payments made by third-party payors.

#### **5.4.3 Disclosure of Information**

Title XIX is part of the Federal Social Security Act. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulations of the Department of Health and Human Services or upon the express authorization of the Secretary of Health and Human Services.

A provider may disclose records or information acquired under the DC Medicaid Program only when the record or information is to be used in connection with a claim or to verify the utilization of DC Medicaid benefits and the disclosure is necessary for the proper performance of the duties of any officer or employee of:

(a) DOH

- (b) Any public, private agency or organization under an agreement with MAA in meeting requirements of the DC Medicaid Program
- (c) MAA
- (d) A representative of the Secretary of Health and Human Services

#### **5.4.4 Penalties for Non-Compliance**

MAA may terminate agreements with providers who fail to maintain and provide medical and fiscal records as described in the Provider Agreement. If District or Federal review shows that MAA paid for services that a provider failed to document as required by the provider's agreement, said provider is subject to termination pursuant to CHCF rules at DC Register 3870, August 3, 1984. The purpose of the rules is to establish administrative procedures for:

- 1) Restricting or terminating the participation of Medicaid providers who defraud or abuse the program, or fail to abide by the conditions of participation as set forth in pertinent laws and the provider agreement;
- 2) Suspending at the direction of the federal government those providers convicted of; "program-related" crimes;
- 3) Recovering overpayments to providers;
- 4) Determining program reimbursement based upon provider cost reports; and
- 5) Requesting reinstatement of a provider in the Medicaid program.

If MAA finds, prior to paying a claim, that service is not fully documented by the provider (cited in provider's medical records), payment shall not be made.

### **5.5 Authorized Signature**

The provider entity who signed the Provider Agreement must enter an original signature on every claim. The provider may delegate signatory authority to an agent subsequent to written notice to MAA. The

written notice must articulate an authorized name, the effective date of the delegation, and an original signature of the agent on the Delegation of Signatory Authority Form (see example on following page). The completed form must be submitted to ACS. The address is included in Appendix A. If MAA does not have a valid Delegation of Signatory Authority Form, reimbursement for services submitted through unauthorized signatures may be delayed or denied.

**DELEGATION OF SIGNATORY AUTHORITY****PROVIDER NAME** \_\_\_\_\_ **PROVIDER NUMBER** \_\_\_\_\_

TYPED NAME OF INDIVIDUAL(S) SIGNATURE OF INDIVIDUAL(S)	EFFECTIVE DATE	TERMINATION DATE

I/we authorize the individuals listed above to sign invoices on my/our behalf for presentation to the DC Medicaid Program certifying to the statements on the invoice and that the services claimed for reimbursement were rendered in accordance with the executed provider agreement and subsequent manuals and instructions.

As the enrolled entity, I/we understand that the delegation of signature authorization to the individuals listed above does not in any way diminish my/our responsibilities in accordance with the executed provider agreement.

\_\_\_\_\_  
**Individual Provider's Signature**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Corporate name of the group, institute, medical facility, firm, or government, i.e., the provider entity.**\_\_\_\_\_  
**Address**\_\_\_\_\_  
**Phone Number**

**Signature of Individuals Responsible to Enforce Compliance with these Conditions of Participation within the Corporation.**

\_\_\_\_\_  
**Chief Executive Officer**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Chief Medical Officer**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Principal Corporate Officer**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Other Corporate Officers & Titles**\_\_\_\_\_  
**Date**

## **5.6 Utilization Review**

In accordance with Section 1902 (a) (30) of the Social Security Act, MAA has established procedures for reviewing the utilization of, and payment for, all Medicaid services. Accordingly, providers are required, upon request, to provide MAA, designated MAA agents, the Department of Justice, or the Secretary of Department of Health and Human Services with medical records. In addition, providers must fully cooperate with audits and reviews made by MAA to determine validity of claims or the medical necessity of services rendered by the provider.

Any of the above entities have the right to request complete information about the ownership of any contractor with whom the provider has had business transactions totaling more than \$25,000 during the twelve-month period ending on the date of the request. In addition, requests may be made about significant business transactions between the provider and any wholly owned supplier, or subcontractor, during the 5-year period on the date of the request. This information must be supplied within 35 days of request.

## **5.7 Consequences of Misutilization and Abuse**

If routine utilization review procedures indicate that services have been billed for, that are unnecessary, inappropriate, contrary to customary standards of practice, or violate Medicaid regulations, the provider will be notified in writing. Claims that have not been approved will be delayed or suspended for a period not to exceed 120 days. The provider may need to explain billing practices and provide records for review. When appropriate, peer review may be convened. Subsequent to the investigation, termination may be warranted pursuant to rules DC Register 3870, August 3, 1984. Providers will be required to refund payments made by Medicaid if the services are found to have been billed and been paid by Medicaid contrary to policy, the provider has failed to maintain adequate documentation to support their claims, or billed for medically unnecessary services.

## **5.8 Quality Assurance Program for DC Medicaid Managed Care**

MAA is responsible and accountable for all quality assurance activities implemented by the Department's Quality Assurance Program. Components of this Quality Assurance Program are as follows:

- MAA's internal quality assurance plan which will include the tracking and monitoring of provider utilization, the monitoring of program goals and objectives and fraud surveillance

- Professional Standards Review Organization (PSRO) contracted with MAA to perform retrospective claim audit, pre-authorization of specific services and review of DRG outliers
- External Auditor contracted with MAA to conduct quality review surveys of the DC Medicaid Program

The process of quality assurance is not complete without the documentation and dissemination of findings and results. All entities both internal and external to the Department are charged with scrutinizing the quality of health care rendered to Medicaid recipients. All providers participating in the DC Medicaid Program are required to comply with the reporting standards established by the Department. Participating providers shall receive periodic reports detailing quality assurance findings. Action shall be taken against providers that fall outside the norm and cannot provide adequate explanation of these deviations.

## **5.9 Consequences of Fraud**

If an investigation by DOH shows that a provider submitted false claims for services not rendered or provided assistance to another in submitting false claims for services not rendered, DOH will initiate termination proceedings pursuant to rules at DC Register 3870, August 3, 1984. In addition to administrative action, the case record will be referred to the Medicaid Fraud Unit, Office of the Corporation Counsel, for further review and criminal prosecution under District and Federal law. Sanctions for criminal violations will be imposed pursuant to District and Federal law.

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## **6.0 ADMINISTRATIVE ACTIONS**

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The following administrative actions can be taken in response to provider misutilization or fraud and abuse.

### **6.1 Restitution**

If a provider has knowingly billed and been paid for undocumented or unnecessary medical services, MAA will review the error and determine the amount of improper payment. The provider will be required to either submit payment or provide repayment through future claims. If the 100% review of disputable claims becomes impractical, random sampling techniques will be implemented to determine the amount of the improper payment. An appeal by a provider is not a sufficient reason to postpone restitution procedures. In addition, the provider is prohibited from billing the recipient for amounts the provider is required to repay.

### **6.2 Termination**

A Provider Agreement can be terminated for cause prior to term completion (where applicable) if evidence indicates that the provider:

- Is not complying with duly promulgated regulations of DC Medicaid
- Is not complying with the terms of the Provider Agreement
- Has not been licensed, registered, and/or certified under state or District law while providing services
- Has been suspended or terminated from Medicare
- Has been convicted of a Medicaid-related criminal offense
- Has had a disciplinary action against him entered on the records of the state or District licensing or certifying agency

- Has had a controlled drug license withdrawn
- Has refused to permit duly authorized District or Federal representatives to examine medical or fiscal records
- Has dispensed items or services to excess that could be harmful, grossly inferior in quality, or delivered in an unsanitary manner in an unsanitary environment
- Has falsified information related to a request for payment
- Has knowingly accepted Medicaid reimbursement for services provided to recipients who have borrowed or stolen Medicaid identification cards

Termination proceedings will be invoked pursuant to rules at DC Register 3870, August 3, 1984.

### **6.2.1 Notification**

When a Provider Agreement is terminated, the provider will receive a Notice of Termination from MAA. The notice will include the reason for the action, the effective date of the action, and the repercussions for the action. Upon notification of termination, the provider may submit all outstanding claims for allowable services rendered prior to the date of termination. These claims must be submitted within 45 days of the effective date of the termination.

In addition, upon termination of the Provider Agreement, Medicaid may release all pertinent information to:

- The Centers for Medicaid and Medicare Services (CMS-formerly known as HCFA)
- District, State, and local agencies involved in providing health care
- Medicaid agencies located in other states
- State and county professional societies
- General public

### **6.2.2 Consequences of Termination**

Upon termination, the provider will be prohibited from receiving payment, either directly or indirectly, from DC Medicaid. This includes payment for professional or administrative services through any group practice, medical, clinic, medical center, individual provider, or other facility.

## **6.3 Appeal Process**

A provider may request a formal review if he disagrees with a decision made by MAA. Rules governing appeals filed by providers are cited in the Provisions for Fair Hearings, DC Code Title 3-210.1 - 3-210.18 and the DC Register page 3870 - 3885, August 3, 1984. Areas that may be appealed include, but are not limited to, the following:

1. Appeals regarding denial of payment for unauthorized services
2. Appeals regarding termination of a provider agreement
3. Appeals regarding denial of enrollment as a provider in the DC Medicaid or Waiver Programs.

Written requests for appeals must be sent to the address in Appendix A. Appeals regarding termination of the Provider Agreement must be sent in writing to the address listed in Appendix A.

A copy of all appeals must be sent to MAA at the address in Appendix A.

## **6.4 Reinstatement**

The provider must send a written request to MAA to be considered for reinstatement. This written request should include statements from peer review personnel, probation officers (where applicable), or professional associates on the provider's behalf. In addition, the provider should include an individual statement of request for reinstatement.

### **6.4.1 Criteria for Reinstatement**

MAA will take the following into consideration when a provider has made a request for reinstatement:

- Severity of the offense

- Negative licensure action
- Court convictions that are Medicaid-related
- Pending, unfulfilled claims or penalties

### 6.4.2 Notification of Action

MAA will notify the provider in writing within 45 days of the request for reinstatement. The notification will indicate the disposition of the request.

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## **7.0 RECIPIENT ELIGIBILITY**

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This subsection provides an overview of recipient eligibility.

### **7.1 Eligibility Determination**

The Bureau of Eligibility Determination, Income Maintenance Administration (IMA), determines recipient eligibility for the DC Medicaid Program.

The Office of Information Systems operates the Automated Client Eligibility Determination System (ACEDS), which determines and tracks eligibility, providing integrated automated support for several District of Columbia programs, including Medicaid. The ACEDS eligibility information is directly linked to EVS, making it readily available to providers.

### **7.2 Eligibility of Persons**

Individuals may be eligible for DC Medicaid by either qualifying under a “categorically needy” program or by meeting the conditions to be considered “medically needy”. Categorically needy programs include Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and refugee programs. Medically needy recipients are those who do not qualify for cash benefits under a categorical program but meet the criteria to qualify as a medically indigent Medicaid beneficiary. The DC Medicaid Program does not cover medically indigent persons who are not eligible under a category that entitles receipt of federal financial participation. Following is a more specific list of groups eligible in the DC Medicaid Program:

1. Persons determined to be eligible for a grant through the TANF program
2. Pregnant (medically determined) women who would be eligible for TANF if the child were born and living with the mother
3. Pregnant women and infants up to one year of age with family incomes up to 133% of the federal poverty level

4. Persons who are age sixty-five or over, blind, or disabled, and who receive Supplemental Security Income (SSI) grants
5. Person who are sixty-five or over, or disabled and who meet more restrictive requirements than SSI
6. Persons who would qualify for SSI except for certain Social Security cost-of-living increases
7. Persons in medical facilities who, if they left such facilities, would qualify for SSI except for income
8. Persons who have become ineligible for Medicaid who are enrolled in an HMO that is qualified under Title XIII of the Public Health Service Act
9. Persons who would be eligible for TANF if their work-related child care costs were paid from earnings rather than by a government agency
10. Children in licensed foster care homes or private child care institutions for whom public agencies are assuming financial responsibility
11. Children receiving subsidized adoption payments
12. Persons who receive only a supplemental payment from the District
13. Certain disabled children age eighteen (18) or under who live at home, but would be eligible if they lived in a medical institution
14. Pregnant women and children up to age five who are under 100% of the federal poverty level

### 7.3 Eligibility Identification

It is the responsibility of the provider to always verify that the patient is eligible for Medicaid.

### 7.3.1 Medical Assistance Card

When first determined eligible, each Medicaid recipient receives a plastic Medical Assistance Card from the Income Maintenance Administration containing his name, social security number, date of birth, sex, and an eight-digit identification number, which may include two leading zeroes.

If the recipient has provided this information to the eligibility-determining agency, a provider should ask the recipient if he has other health insurance coverage not shown on the card. The provider is obligated to determine that the person to whom care is being rendered is the same individual listed on the eligibility card.

<p align="center"><b>MEDICAL ASSISTANCE CARD</b>  <b>DISTRICT OF COLUMBIA GOVERNMENT</b>          (READ INSTRUCTIONS ON BACK)</p>		
<div style="border: 1px solid black; height: 20px; width: 150px; margin-bottom: 5px;"></div>		<p>SIGNATURE OF NAMED          INDIVIDUAL (Head of          Family if person named          cannot write)</p>
<p>SEX:          SSN:          NAME:</p>	<p>INS.C.</p>	<p>RRN:          DOB:</p>
<p align="center">DC IDENTIFICATION NO.</p>		

#### INFORMATION

1. It is against the law for this card to be used by or for anyone but the person whose name is printed on the front. You will be prosecuted under applicable Federal law if misused.
2. Carry this card with you at all times. Parent or guardian should hold cards for young children.
3. You must show this card to your doctor, hospital, or clinic before obtaining health services and to the druggist if you are obtaining prescription medicine.
4. If you have any questions on services covered by this card, telephone (202) 727-5506.
5. If there is any change in your income, resources, family size or address, you must notify your case worker within two weeks. For general medical assistance information, call (202) 724-5506.

The back of the Medical Assistance Card provides information to the recipient that gives specific information relevant to its use.

### 7.3.2 Notice of Presumptive Eligibility

To encourage greater participation in obtaining prenatal care, DHS clinics and Federally Qualified Health Centers (FQHCs) are authorized to determine pregnant women temporarily (presumptively) eligible for Medicaid while IMA determines her ongoing Medicaid eligibility. The temporary eligibility will allow immediate receipt of all Medicaid-covered ambulatory services that are related to pregnancy, and the patient will be issued a dated Notice of Presumptive Eligibility, a copy of which follows.

A District of Columbia Identification Number (DC ID#) will be established/issued no later than fourteen days from the date of the Notice by IMA. The Eligibility Verification System (EVS) will then respond

“Medicaid Eligible,” and claims may be submitted routinely to ACS. The address is listed in Appendix A.

In the meantime, it is expected that most services will be furnished by the DHS clinic or the FQHC; however, should a patient require your services, the Notice of Presumptive Eligibility will certify her as temporarily Medicaid eligible. Claims for services provided within the fourteen day period should be submitted to the address listed in Appendix A.

If you have questions concerning claim submission, please contact the Provider Relations Department at ACS; questions regarding eligibility determinations should be directed to the Income Maintenance Administration. The addresses and telephone numbers are included in Appendix A.

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**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH**

**NOTICE OF PRESUMPTIVE DETERMINATION**

PROVIDER NAME \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE DETERMINED PRESUMPTIVELY ELIGIBLE \_\_\_\_\_

[ ] You have been found temporarily eligible for Medicaid. You must go to the IMA Service Center to apply for Medicaid. If you **do not** apply for Medicaid, your eligibility will terminate by the last day of the month after the month you were determined eligible. Temporary Medicaid will cover services related to your pregnancy. Delivery costs will not be covered unless you apply at a DHS Service Center and are eligible. Call 202/724-5506 for the DHS Service Center in your area.

If you **do** apply for Medicaid at the DHS Service Center, you **may** be eligible to receive Medicaid coverage for all pregnancy-related services (including delivery) up to and for 60 days after the end of your pregnancy. Please go to the DHS Service Center as soon as possible so that you can receive Medicaid throughout your pregnancy.

[ ] You have been found **ineligible** for presumptive eligibility. However, you may be eligible for Medical Assistance. Call the Medicaid Information Unit on 202/724-5506 for the Service Center in your area.

DHS \_\_\_\_\_ A

Original to:

645 H St., N.E.  
Washington, DC  
20002

Copy to Applicant

Copy for Provider File

## **7.4 Provider Responsibility**

The provider is responsible for the following eligibility verification activities.

### **7.4.1 Eligibility Verification**

It is the responsibility of the provider to ensure the patient is DC Medicaid eligible on the date of service. If a provider supplies services to an ineligible recipient, the provider cannot collect payment from DC Medicaid. The provider should verify:

- Recipient's name and identification number
- Effective dates of eligibility
- Services restricted to specified providers
- Third-party liability

The provider must verify the recipient's eligibility by calling the Eligibility Verification System (EVS) using a touch-tone telephone (telephone number included in Appendix A) and supplying the recipient identification number found on the recipient's ID card. EVS receives eligibility information from ACEDS which is operated by the Office of Information Systems.

### **7.4.2 Third-Party Liability**

Third-party liability (TPL) identifies primary payor resources outside of DC Medicaid who should be billed for the services, i.e., Workmen's Compensation, CHAMPUS, Medicare, private insurance carriers, etc. Since DC Medicaid is a payor of last resort, the provider must bill other resources first. When payment or denial of payment from the third party has been received, all documentation related to the action must be attached to the claim when billing DC Medicaid for a service. It is incumbent on the provider to discover if the recipient has other resources. Information about TPL must be entered on the claim form and should be kept in the patient's records.

In subrogation cases, MAA should be notified. All recoveries should be turned over to MAA immediately to offset payments already made by MAA on behalf of the recipient.

### **7.4.3 Medicaid Recipient Restriction Program**

## 7.0 Recipient Eligibility

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MAA may restrict a DC Medicaid recipient to one designated primary care provider and to one designated pharmacy, when there is documented evidence of abuse or misutilization of services. For the purposes of this program, a primary care provider is a health care practitioner who takes responsibility for the continuous care of a patient, preventive as well as curative. Primary care providers are: internists, family practitioners, general practitioners, pediatricians, health maintenance organizations, comprehensive neighborhood health centers, etc.

Medicaid Recipient Restriction is a corrective process by which a recipient is locked in for one year or more to the services of one designated pharmacy and one designated primary care provider who will be responsible for the management of the recipient's total health care. This restriction will not apply when there is need for a second opinion or when there is a medical emergency.

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## **8.0 CLAIMS PROCESSING PROCEDURES**

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Claims go through many stages before they are finally processed; they are received, reviewed, coded, input, and edited.

In order to ensure that the DC Medicaid claim is processed according to DC Medicaid policy, an advanced Medicaid Management Information System (MMIS) has been developed to adjudicate and price claims. This chapter outlines the claims process.

### **8.1 Receive and Record**

Claims are received by ACS in one of two media: hard copy or electronic. Hard copy claims are handwritten or generated by computer. Standardized forms have been developed for the submission of services for payment. Standardization ensures appropriate entry and formatting of claims.

DC providers have the option of billing via cartridge, diskette or EDI (Electronic Data Interchange). WINASAP 2000 has been developed by ACS to give DC Medicaid providers the capability for accelerated submission of Medicaid claims. Submitting claims electronically drastically reduces the time required for Medicaid claims to be prepared for the Medicaid Management Information System (MMIS). Electronic submission eliminates the process of document preparation, mailing, claims receipt, and data entry. Using electronic submission, claims are transmitted directly to EDI or received in electronic format, then uploaded to the MMIS the same day of receipt.

Hard copy claims are received in the mailroom where they will undergo a review process.

### **8.2 Review**

After hard copy claims have been received, they are reviewed for essential data. If essential data is missing, the claims will be returned to the provider (RTP). A claim will be rejected if any of the following situations occur:

- Original provider signature is missing (stamped signatures are not acceptable)
- Provider Medicaid identification number is missing

- Recipient Medicaid identification number is missing
- Date(s) of service is missing
- Attachments (if required) are missing
- Claim is unable to image (too light)
- Billing amount is missing

Any claim that is RTP will be accompanied by an RTP letter. If the claim was submitted as a hard copy, the original claim can be corrected. If the claim was originally submitted electronically, it can be resubmitted electronically or the claim can be transferred to hard copy for resubmission.

### 8.3 Transaction Control Number

Claims that are not rejected receive a tracking control number (TCN). This is a unique tracking number assigned to each claim. The TCN consists of 17 numeric digits. The first position designates the document input medium indicator. The next five digits indicate the year and Julian date. The next two digits designate the image machine number followed by the next three digits, which designate the batch number. The following three digits designate the type of document (i.e., new document, credit or adjustment), followed by the document number. The last 2 digits designate the line number.

### 8.4 Input

Claims that have been accepted and have received a TCN are sent to data entry. After these claims have been keyed by data entry operators, the MMIS starts the editing process. If edits appear, they are then worked by the resolutions unit. Edits give operators the opportunity to correct errors. The claims are then entered into the MMIS for the processing.

### 8.5 Edits

When the claims data has been loaded into the computer, it is edited to ensure compliance with the following DC Medicaid requirements:

- Provider eligibility
- Recipient eligibility
- Valid and appropriate procedure, diagnosis, and drug codes

- Reasonable charges
- Duplicate claims
- Conflicting services
- Valid dates
- Other Medicaid requirements.

The status that is assigned to each claim is dependent on compliance with the requirements. The assigned status of each claim will be either paid, denied, or pended.

The Remittance Advice (RA) document sent to providers shows the status of each claim submitted by the provider and entered into the MMIS. The claims information is sorted on the RA in the following order:

- Paid original claims
- Paid adjustment claims
- Denied original claims
- Denied adjustment claims
- Pended claims (in process)
- Paid claims mtd
- Denied claims mtd
- Adjusted claims mtd
- Paid claims ytd
- Denied claims ytd

### 8.5.1 Approval Notification

Claims that meet all requirements are paid during the next payment cycle. Twice a month, the provider will receive a Remittance Advice (RA) listing all paid, denied and pended claims in the system, sorted in the following sequence:

- RA number
- Claim input form indicator
- Claim status
- Recipient last name
- Recipient first name

- TCN
- Provider zip code
- Pay to provider number

The provider will also receive a reimbursement check. The RA will include claim amounts that have been processed and a total of all paid claims.

Claims previously paid incorrectly may be adjusted or voided. Voids will appear as credits; adjustments will appear as two transactions, debit and credit.

Adjustments/voids need to be initiated by the provider since. Errors can only be corrected by the provider **after** the claim has been paid and appears on the RA. It is the responsibility of the provider to make corrections when errors are made.

The following examples show the importance of adjusting or voiding a previously adjudicated claim on which errors have occurred:

- The provider treated John Smith, but inadvertently coded a Recipient Identification Number of Jane Smith who may or may not be the provider's patient. The provider will need to **void** the claim for Jane Smith and submit an original claim for John Smith giving the correct identification number.
- On the original claim the provider entered the incorrect charge for an accommodation. The provider will need to **adjust** (correct) the claim in order to obtain the correct reimbursement.
- The provider submits a claim in which an incorrect procedure code was used. In this case, the code was for removal of an appendix. This was not the procedure performed but the claim was paid according to the procedure listed. The provider will need to **adjust** (correct) this claim via an adjustment and enter the correct code for the procedure performed. This is an important step because should the patient ever require an appendectomy, that claim would otherwise be denied because the record reflects that the appendix had previously been removed.

The provider will be paid by check for all paid claims in accordance with current guidelines. Payments to providers may be increased or decreased by MAA to accommodate previous overpayments, underpayments or an audit.

### **8.5.2 Denied**

Claims that do not meet DC Medicaid edit requirements will not be paid. All denied claims are listed on the RA in alphabetical order by recipient last name. Denial reasons are listed on the RA as well. Listed below are some examples of denial reasons:

- Recipient not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claims submitted more than six months from date of service (timely filing)

### **8.5.3 Pended**

Claims that do not meet the edit requirements cannot be paid until discrepancies have been resolved. In order to verify that the claim is in error, the MMIS assigns a status of “Pend” which will outline the problem to resolve the issue.

ACS and MAA resolve all pended claims. The RA will only state that the claim is suspended and will not give a reason.

## **8.6 Timely Filing**

All services to be reimbursed must be billed on the appropriate form, signed, and mailed to ACS or in the case of presumptive eligibility, MAA. All claims must be mailed to their respective P.O. Box, unless otherwise instructed.

To avoid denial, claims must be received within 6 months after the date of service or in the case of inpatient hospital services, 6 months after the date of discharge.

Exceptions may be considered if proof of any of the following conditions exists:

- A retroactive adjustment must be paid to providers who are reimbursed under a retrospective payment plan

## 8.0 CLAIMS PROCESSING PROCEDURES

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- A claim for payment from Medicare has been filed in a timely manner; the agency may pay a DC Medicaid claim or residual relating to the same services within 12 months after the agency or provider receives notice of the disposition of the Medicare claim
- Claims have been delayed due to provider investigation
- The agency has to make payments in accordance with a court order, to carry out hearing decisions or agency corrective actions to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court orders to others in the same situation as those directly affected by it
- Claims have been delayed due to third-party billing
- Medicaid eligibility spend-down has been exhausted, disability determined, or eligibility is retroactive
- Health maintenance or prepaid capitation grants are involved
- Claims have been delayed due to out-of-District billing; out-of-District providers have twelve months from the date of services to submit claims
- A claim has been previously submitted but has not been paid
- A claim has been delayed due to authorization requirements of MAA.

The processing of a new provider's enrollment application may cause some of the provider's claims to exceed the six-month filing limit. To prevent automatic denial of claims that fall within the effective date of the Provider Agreement but exceed 6 months from the date of service, mail claims directly to the ACS claims P.O. Box listed in Appendix A. In addition, a hard copy claim must be received for any exceptions authorized for reimbursement. Authorized exceptions cannot be accepted electronically.

### 8.7 Remittance Advice

RA's are the vehicle used by MAA to communicate with the providers on the status of claims. ACS is responsible for creating RAs twice a month. The RA provides pertinent information relevant to the

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## 8.0 CLAIMS PROCESSING PROCEDURES

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claim, the errors that have been detected, and the payment amount. Listed below is a description of each field on the RA. This information will help you to better understand the information on the RA.

### REMITTANCE ADVICE EXPLANATION

FIELD NO.	FIELD NAME	EXPLANATION
1	TO	The name of the Medicaid provider number of the payee provider who is getting the remittance advice
2	RA NO	The remittance advice number associated with the check
3	DATE PAID	Date Paid
4	PROVIDER NO	The Medicaid provider number of the pay-to-provider
5	PAGE	The page number of the report (leading zeros are suppressed for a specific provider's remittance being printed.
6	PATIENT NAME	Patient name
7	RECIPIENT ID NO	The recipient identification number under which the claim was filed
8	TRANS-CONTROL-NO	The transaction control number of the claim
9	PAID BY MCAID	The Medicaid reimbursement amount of the claim
10	COPAY AMT. or PATIENT RESPONS	The copay amount of the claim
11	MED REC NO	This is the claim medical record number carried as ten characters

## 8.0 CLAIMS PROCESSING PROCEDURES

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12	LINE	The line number of the line item. Up to 21 line items on a claim
13	SVC-DATE	The date of service of the line item. Only the from date of service is being printed for HCFA-1500 claims
14	PROC	The procedure code field in the claim line item
15	MODS	The procedure code (modifier(s)) in a claim line item
16	UNITS	The units of service for the claim line item. This is the units of service for which the provider is to be paid
17	PERF. PROV.	The line item provider number who rendered the service (also called the treating provider number). This will be blank for all line items but the first line item for non-institutional/other claims. It will be blank for all transportation line items.
18	EOB	Two explanations of benefits codes appear for each claim header and for each claim line (if lines are contained in the claim for the claim type). These codes are printed for suspended and denied claims. For paid claims, an alpha value in the EOB code indicates the claim has been cutback and the code is the reason for the cut-back. An explanation of all the EOB codes and the cutback codes on the provider's RA is printed at the end of the provider's RA.
19	EOB CONTINUATION	The claim carries only two EOB fields. If exception codes are posted to the claim that could have caused the claim to be denied and the EOB codes related to these exception codes are not the same as the EOB

## 8.0 CLAIMS PROCESSING PROCEDURES

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codes on the claim record, then the EOB codes are printed on this line.

20	CLAIM TYPE	The claim input form indicator description
21	CLAIM STATUS	The claim status description
22	REMITTANCE TOTALS	This section name is used to denote the total of all the claims for this provider's remittance advice
23	PAID ORIGINAL CLAIMS	The number of claims and associated dollars for original claims paid on this provider's remittance advice
24	PAID ADJUSTMENT CLAIMS	The number of claims and associated dollars for credits and adjustments paid on this provider's remittance advice. Gross adjustments are tallied as adjustment claims
25	DENIED ORIGINAL CLAIMS	The number of claims and associated dollars for original denied claims on this provider's remittance advice
26	DENIED ADJUSTMENT CLAIMS	The number of claims and associated dollars for adjustments denied on the provider's remittance advice
27	PENDED CLAIMS (IN PROCESS)	The number of claims and associated dollars for original claims and adjustments that are currently on the suspended claims file
28	AMOUNT OF CHECK	The sum of reimbursements equals the amount that the provider will receive in the form of this check.
29	THE FOLLOWING IS	

A DESCRIPTION OF  
THE EOB CODES THAT  
APPEAR ABOVE

This paragraph prints if any suspense or denial EOB codes appear for any header claims or any claim line-item for the claim type being printed for the provider. The EOB code itself prints down the page followed by the actual text for the EOB code from the EOB text file from online MMIS. Any cutback codes that appear on the RA are also listed and explained here (only applies to claims paid). Any adjustment reasons that appear on the RA are also listed and explained here.

30	COUNT	This is the occurrence counter for each of the EOB codes that print in the EOB code explanation section at the end of the RA for each provider. The count is simply a tally of all occurrences of the EOB code. The same is true for cutback codes and adjustment reasons.
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**REMITTANCE ADVICE EXPLANATION (MEDICARE PART B CROSSOVER)**

<b>FIELD NO.</b>	<b>FIELD NAME</b>	<b>EXPLANATION</b>
1	TO	The name of the Medicaid provider number of the payee provider who is getting the remittance advice
2	RA NO	The remittance advice number associated with the check
3	DATE PAID	Date Paid
4	PROVIDER NO	The Medicaid provider number of the pay-to-provider

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## 8.0 CLAIMS PROCESSING PROCEDURES

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5	PAGE	The page number of the report (leading zeros are suppressed for a specific provider's remittance being printed).
6	PATIENT NAME	Patient name
7	RECIPIENT ID NO	The recipient identification number under which the claim was filed
8	TRANS-CONTROL-NO	The transaction control number of the claim
9	MCARE PAID AMT	The amount paid by Medicare in the line item
10	MCARE APPRD AMT	The amount approved by Medicare in the line item
11	DEDUCTIBLE	The Medicare deductible amount applicable in the line item
12	COINS AMT	The Medicare coinsurance amount applicable in the line item
13	MCAID PAID AMT	The Medicaid reimbursement amount of the claim
14	MED RCD NO	This is the claim medical record number carried as ten characters
15	SVC-DATE	The date of service of the line item. Only the from date of service is being printed for HCFA-1500 claims
16	PERF-PROV	The treating provider number in the line item
17	EOB	Two explanations of benefits codes appear for each claim header and for each claim line (if lines are contained in the claim for the claim type). These codes

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## 8.0 CLAIMS PROCESSING PROCEDURES

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are printed for suspended and denied claims. For paid claims, an alpha value in the EOB code indicates the claim has been cutback and the code is the reason for the cut-back. An explanation of all the EOB codes and the cutback codes on the provider's RA is printed at the end of the provider's RA.

18	EOB CONTINUATION	The claim carries only two EOB fields. If exception codes are posted to the claim that could have caused the claim to be denied and the EOB codes related to these exception codes are not the same as the EOB codes on the claim record, then the EOB codes are printed on this line.
19	CLAIM TYPE	The claim input form indicator description
20	CLAIM STATUS	The claim status description

## **8.8 Inquiries**

In accordance with HIPAA privacy guidelines, when making calls to the Provider Inquiry Unit, you may be asked for the following information:

- The D.C. Medicaid provider number
- The name of the provider
- The name of the representative calling on behalf of the provider
- The provider tax identification number.

Please have this information readily available so that we may assist you.

When making written and telephone inquiries related to RA status, providers must provide ACS with the date of the RA and the TCN for the claim in question. All written inquiries should be mailed to the Provider Inquiry P.O. Box listed in Appendix A.

REMITTANCE ADVICE  
DCMC8000-R001 (CP-O-12)  
AS OF 01/31/02  
03/15/02

DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE

REMITTANCE ADVICE

[1]	[2]	[3]	[4]	[5]
TO: JOHN SMITH	R.A. NO.: 0000002	DATE PAID: 01/31/02	PROVIDER NUMBER: 010008500	
PAGE: 1				

[6]	[7]	[8]	[9]	[10]	[11]	[12]	[13]	[14]	[15]	[16]	[17]	[18]	[19]
**** PATIENT NAME ****	RECIP ID /	TRANS-CONTROL-NUMBER /	BILLED	OTHER	PAID BY	COPAY	MED RCD NUM /						
LAST	FIRST MI	LINE	SVC-DATE	PROC/MODS	UNITS	AMT.	INS.	MCAID	AMT.	PERF.	PROV.	PLAN	
FEE	EOB	EOB											

[20]	[21]
* * * CLAIM TYPE: HCFA 1500	* * * CLAIM STATUS: PAID

ORIGINAL CLAIMS:

FRANKLIN	ALVIN R	70000444	0-02011-11-001-0001-00	500.00	0.00	175.00	0.00						
000 000													
	01	01/01/02	Y1000	1	500.00	0.00	175.00	0.00	010008500	F	W002		
000 000													

\*\*\*\*\*  
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* * * CLAIM TYPE: HCFA 1500	* * * CLAIM STATUS: IN PROCESS
ORIGINAL CLAIMS:	

*BULLOCK	DEMET	70000453	0-02011-11-001-0003-00	500.00	0.00	0.00	0.00						
900 000													
	01	01/01/02	Y1000	1	500.00	0.00	0.00	0.00	010008500				
900 000													

[22]	REMITTANCE TOTALS	NUMBER OF CLAIMS	AMOUNT
[23]	PAID ORIGINAL CLAIMS:	1	175.00
[24]	PAID ADJUSTMENT CLAIMS:	0	0.00
[25]	DENIED ORIGINAL CLAIMS:	0	0.00
[26]	DENIED ADJUSTMENT CLAIMS:	0	0.00
[27]	PENDED CLAIMS (IN PROCESS):	1	0.00
	PAID CLAIMS MTD:	1	175.00
	DENIED CLAIMS MTD:	0	0.00
	ADJUSTED CLAIMS MTD:	0	0.00
	PAID CLAIMS YTD:	1	175.00
	DENIED CLAIMS YTD:	0	0.00
	ADJUSTED CLAIMS YTD:	0	0.00
[28]	AMOUNT OF CHECK:		175.00

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: [29] [30] COUNT:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM. 2

REMITTANCE ADVICE  
 DCMC8000-R001 (CP-O-12) DISTRICT OF COLUMBIA MEDICAL ASSISTANCE ADMINISTRATION  
 AS OF 01/31/02 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE  
 03/15/02

R E M I T T A N C E A D V I C E

[1] [2] [3] [4] [5]

TO: HAROLD B. GLICKMAN D R.A. NO.: 0000007 DATE PAID: 01/31/02 PROVIDER NUMBER: 100144500  
 PAGE: 1

[6] [7] [8] [9] [10] [11] [12] [13] [14]  
 \* PATIENT NME \* RECIP ID TRANS-CONTROL-NUMBER / MCARE MCARE DEDUCT- COINS. MCAID MED RCD NUM /  
 [15] [16] [17]

[18]  
 LAST FI MI LINE SVC-DATEPROC/MODS UNITS PAID AMT APPRD IBLE AMT. PAID AMT PERF-PRV S PLAN FEE  
 EOB EOB

\*\*\*\*\*  
 \*\*\*\*\*

[19] [20]  
 \* \* \* CLAIM TYPE: MEDICARE PART B CROSSOVER \* \* \* CLAIM STATUS: IN PROCESS

ORIGINAL CLAIMS:  
 GENERAL INSTRUCTIONS

*ABNEY	M R	70000025	0-02004-11-002-0024-00	45.00	0.00	45.00	5.00	0.00	
900									
		01	01/01/02 27880	1	45.00	45.00	45.00	5.00	0.00
900									
*MORRIS	T D	70007875	0-02004-11-002-0023-00	45.00	0.00	5.00	5.00	0.00	
900									
		01	01/01/02 S8013	2	45.00	45.00	5.00	5.00	0.00
900									HSPC
*VAAS	C C	70305369	0-02004-11-002-0022-00	45.00	0.00	45.00	5.00	0.00	
900									
		01	01/01/02 S8013	1	45.00	45.00	45.00	5.00	0.00
900									

REMITTANCE TOTALS	NUMBER OF CLAIMS	AMOUNT
PAID ORIGINAL CLAIMS:	0	0.00
PAID ADJUSTMENT CLAIMS:	0	0.00
DENIED ORIGINAL CLAIMS:	0	0.00
DENIED ADJUSTMENT CLAIMS:	0	0.00
PENDED CLAIMS (IN PROCESS):	3	0.00
PAID CLAIMS MTD:	0	0.00
DENIED CLAIMS MTD:	0	0.00
ADJUSTED CLAIMS MTD:	0	0.00
PAID CLAIMS YTD:	0	0.00
DENIED CLAIMS YTD:	0	0.00
ADJUSTED CLAIMS YTD:	0	0.00

AMOUNT OF CHECK:	0.00
------------------	------

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:	COUNT:
900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.	

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## 9.0 BILLING INFORMATION

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This section provides general billing information for use by providers when submitting claims.

### 9.1 Billing Procedures

**Each provider must supply their own standard claim form for the services provided. ACS only distributes Prior Authorization (719A) and Medicaid Laboratory Invoice for Ophthalmic Dispensing forms.**

### 9.2 Electronic Billing

DC Medicaid will accept transmission of claims electronically. Currently DC Medicaid receives claims in the following media:

- Cartridge
- Diskette
- WINASAP 2000

ACS/EDI supports this function. Electronic claim submission provides for timely submission and processing of claims. It also reduces the rate of pended and denied claims.

Providers who are interested in receiving cartridge billing instructions should indicate this interest on their enrollment application. Permission from the DC Medicaid Program is required prior to submitting cartridge claims. Procedures specific to cartridge billing are sent to providers approved to submit claims in this manner. If you are already enrolled in the program and would like information on electronic claims billing, please contact the ACS at the number and address listed in Appendix A.

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**REQUEST FOR FORMS**

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Place indicate the “Type of Form” you are requesting. Enter the quantity of forms you are requesting in the “Number of Forms” column.

**SUBMITTED BY****SUBMIT TO**

PROVIDER NAME: \_\_\_\_\_

PROVIDER I.D. NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

DISTRICT MEDICAID

CLAIMS PROCESSING

ACS

P.O. BOX 34734

WASHINGTON, DC 20043

**TYPE OF FORMS****QUANTITY**MEDICAID LABORATORY INVOICE FOR OPHTHALMIC  
DISPENSING, OPTION II

PRIOR AUTHORIZATION (719A)

### **9.3 Medicare/Medicaid Crossover Billing**

When a recipient has been determined as dually-eligible (Medicare and Medicaid), Medicare should always be billed first. The Medicare claim must include both the patient's Medicare and Medicaid identification number. After Medicare processes the claim, the claim will be transmitted to ACS for processing electronically.

If Medicare is billed for services to a recipient who is later identified as having Medicaid coverage, the provider should submit a copy of the Medicare claim to DC Medicaid. Again, the Medicare claim must include the patient's DC Medicaid identification number. The Explanation of Medical Benefits (EOMB) from Medicare must be attached to the claim as proof of payment or denial of payment by Medicare and submitted to ACS for processing. Refer to Appendix A for the address to submit these claims.

### **9.4 Medicaid Claims with Third Party Payments**

Medicaid is always the payor of last resort. When a recipient has insurance from another source, employer or private policy, the provider must bill this source first. When the third party payor has made payment for the services, the provider should bill Medicaid for the residual amount.

To bill Medicaid, an original copy of the claim with a copy of the third party payor's EOMB attached, should be submitted to ACS for processing. When interviewing the patient the provider should always question the patient about third party resources available to the patient, regardless of the information supplied through EVS.

### **9.5 Resubmission**

If a claim has been denied due to reasons other than violations of good medical practice or Medicaid regulations, the claim may be resubmitted. An original claim must be submitted; copies will not be accepted. Only claims which have appeared on your remittance advice as denied can be resubmitted. Claims that are still in a Pend status cannot be resubmitted until they have been denied.

Resubmitted copies of claims which lack an original signature or which are illegible will not be processed.

Telephone and/or written claim inquiries regarding non-payment of claims should be made after thirty days from the date the claims were initially submitted to DC Medicaid. **Please be certain that the claim in question has not appeared on any subsequent remittance advice before making an inquiry.** Inquiries on claims that have pended on your remittance advice should be made **after** six months from the date the claim initially appeared as pending.

Instructions for resubmitting a denied claim are as follows:

- Claims must be received within 180 days after the date of service or in the case of inpatient hospital services, 180 days after the date of discharge. Claims must be resubmitted within one year of the RA date on which the claim denied for any reason(s) other than timely filing.
- Complete a new claim form. A copy of the original claim form will be accepted provided that it is clear, legible and has been resigned (a copied or stamped signature will not be accepted).
- Correct any errors that caused the original claim to be denied.
- Do not write anything on the claim except what is requested. Any additional information should be submitted in writing and attached to the claim.
- Attach a copy of the Remittance Advice on which the denied claim appears and any other documentation necessary to have the claim paid (e.g., consent form, isolation form). If more than one resubmitted claim appears on a page of the remittance, a copy of that page should be attached to each claim being submitted.
- Forward all resubmitted claims to the appropriate P.O. Box listed in Appendix A.

If you have any questions regarding these procedures, contact ACS Provider Inquiry at 1-866-752-9233.

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## **10.0 REIMBURSEMENT**

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MAA pays for compensable services and items in accordance with established Federal and District Medicaid regulations and fee schedules.

### **10.1 Maximum Fees or Rates**

The maximum fees or rates shall be the lower of either the provider's charge to the general public, the upper limits set by Medicare, or the fees or rates established by MAA and listed in each individual provider manual.

### **10.2 Changes in Fees or Rates**

DC Medicaid must provide the public with a 60-day notice of a fee or rate category change that affects DC Medicaid expenditures. The expenditure must be affected by one percent or more within the twelve months following the effective date of the change to apply to this provision. This is a federal regulation that is stated in 42 CFR 47.205. The public notice will be published in the District of Columbia Register.

The regulation recognizes the following exceptions:

- Changes affecting single providers, such as a change in the reimbursement rate for a particular hospital
- Changes in response to a court order
- Changes in the Medicare level of reimbursement
- Changes in the annual prospective payment rate
- Current methods of payment with a built-in inflation factor

### **10.3 Payment Inquiries**

Providers may inquire regarding payment of claims. Inquiries must include the TCN, the RA payment date, and the provider's DC Medicaid identification number (this information appears on the provider's RA). Providers should address payment inquiries to the address listed in Appendix A.

Telephone inquiries will be directed to ACS (the telephone number is included in Appendix A).

### **10.4 Paid-in-Full**

Compensable service and item payments made from the DC Medicaid Program to providers are considered paid-in-full. A provider who seeks or accepts supplementary payment of any kind from the DC Medicaid Program, the recipient, or any other person will be required to return the supplementary payment. The provider may, however, seek supplemental payment from recipients who are required to pay part of the cost (co-payment). For example, recipients must pay 50 cents for each prescription (original and refills) for patients who are 21 years of age or older. However, a provider may bill a Medicaid recipient for non-compensable service or item if the recipient has been notified by the provider prior to dispensing the service or item that it will not be covered by DC Medicaid. Examples of these services are transportation services that are not required based on DC Medicaid policy, experimental medical procedures, etc.

### **10.5 Coordination of Benefits**

The DC Medicaid Program is a "last-pay" program. DC Medicaid benefits will be reduced to the extent that benefits may be available through other Federal, State, or local programs or third-party liability to which the recipient may otherwise be entitled. Instructions for billing DC Medicaid after the other source has made payment are contained in this manual in Section 9.4.

#### **10.5.1 Benefit Programs**

Providers must make reasonable efforts to obtain sufficient information from the recipient regarding primary coverage. Medical resources which are primary third parties to DC Medicaid include Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Blue Cross & Blue Shield, commercial insurance, VA benefits, and Workman's Compensation.

### **10.5.2 Coordination of Payment**

The provider must obtain the following information to bill a third party:

- Insurer's name and address
- Policy or Group identification number
- Patient and/or patient's employer's address.

If the District of Columbia MMIS fee rate is more than the third-party fee or rate, the provider can bill DC Medicaid for the difference by submitting a claim and attaching all documentation relating to the payment. If a third-party resource refuses to reimburse the provider, DC Medicaid can be billed by receiving a claim with attached documentation relating to the refusal.

If a Medicaid recipient has Medicare coverage, DC Medicaid can be billed for charges that Medicare applied to the deductible and/or co-insurance. Payment will be made in accordance with the patient liability amount adjudicated by DC Medicaid.

## **10.6 Prescribed or Ordered Services**

DC Medicaid will pay for compensable services or items prescribed or ordered by a practitioner only if they are ordered within the scope of DC Medicaid regulation and good medical practice. Items prescribed or ordered solely for the patient's convenience or that exceed medical needs are not compensable. Payment may not be made for items or services prescribed or ordered by providers who have been terminated from the DC Medicaid Program.

## **10.7 Method of Payment**

The DC Medicaid Program makes direct payments to eligible providers for compensable medical care and related items dispensed to eligible recipients. In order to be reimbursed for an item or service, the provider must be eligible to provide the item or service on the date it is dispensed, and the recipient must be eligible to receive the item or service on the date the item or service was furnished. Payment shall not be made to a provider through a factor either directly, or by power of attorney.

### **10.7.1 Reassignment**

DC Medicaid will not make payment to a collection agency or a service bureau to which a provider has assigned his accounts receivable; however, payment may be made if the provider has reassigned his claim to a government agency or if the reassignment has been ordered by a court.

### **10.7.2 Business Agents**

DC Medicaid will not make payment to a billing service or accounting firm that receives payment in the name of or for the provider.

### **10.7.3 Employers**

DC Medicaid will pay a practitioner through his employer if he is required, as a condition of his employment, to turn over his fees. Payment may also be made to a facility or other entity operating an organized health care delivery system if a practitioner has a contract under which the facility or entity submits the claim.

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## **11.0 PRIOR AUTHORIZATION**

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Procedures to follow for prior authorization are described in this section. Section 12 will provide additional information prior authorization, as appropriate, for specific types of services.

### **11.1 Written Request**

DC Medicaid requires written prior authorization for some medical services. If a service or item requires prior authorization, the provider must submit a Prior Authorization Request/Approval to DC Medicaid. If DC Medicaid approves the request, the provider will receive a prior authorization number. If DC Medicaid denies the request, the service or item will not be considered for reimbursement.

Following is a list of medical services that require written prior authorization:

- Out-of-District non-emergency service/non-participating provider
- Van, wheelchair and non-emergency ambulance transportation to and from medical services
- Durable medical equipment in excess of \$250.00
- Plastic and reconstructive surgery for cosmetic purposes
- Medical supplies in excess of specific limitations
- Selected drug items
- Inpatient hospitalizations for dental procedures and for procedures that are cosmetic and/or medically necessary
- Prosthetic or orthotic appliances in excess of specific limitations

- Transplant Surgeries
- Co-surgeons
- Assistant Surgeons
- Certain vision care services

More complete information regarding services which require prior authorization are included in Section 12.0 of this manual.

## **11.2 Verbal Request**

DC Medicaid will give verbal prior authorization for some medical services. If a verbal prior authorization is granted by DC Medicaid, the provider will be given a prior authorization number. If a verbal prior authorization is denied by DC Medicaid, the service or item will not be considered for reimbursement. ACS will be the authorizing agent for non-emergency medical transportation services.

## **11.3 Authorization Waiver**

All prior authorization requirements are temporarily waived in emergency situations. A situation is considered an emergency if an item or service is critical to the health or required to sustain the life of the recipient. When the emergency ends, the provider must adhere to prior authorization requirements.

## **11.4 Authorization Procedures**

After the Prior Authorization Request/Approval form has been completed, the form should be mailed to the address listed in Appendix A.

If MAA has reviewed and approved the request, a prior authorization number will be assigned to the respective service or item. This number must be included in the appropriate block on the claim form. The completed claim form should be submitted through regular procedures to ACS as listed in Appendix A.

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## **12.0 DC MEDICAID MANAGED CARE**

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Recently MAA implemented a Managed Care Program in the District to help provide quality care to DC Medicaid recipients in a more economical manner. This section explains briefly this program. If you are interested in becoming a participant, contact MAA at the address and number listed in Appendix A.

### **12.1 Background**

In early 1992, Mayor Kelly instructed the District's MAA to design and implement a managed care program for certain Medicaid recipients. Over the course of 1993, the staff of MAA designed the program now known as "DC Medicaid Managed Care". In addition, a waiver application based on that design was sent to the federal Health Care Financing Administration and was approved in April, 1993. MAA's staff worked with a group of Medicaid providers and a group of Medicaid recipients in identifying implementation issues that needed to be resolved so that the program could be implemented with as few difficulties as possible. In preparation, MAA developed provider requirements and capitation rates, program regulations; necessary systems modifications; and developed a horizontal linkage with governmental agencies to ensure a cooperative relationship.

### **12.2 Participants**

The DC Medicaid program serves approximately 120,000 recipients, of whom approximately 80,000 shall be required to participate in the DC Medicaid Managed Care program. Members of the eligible population reside in all eight of the District's wards, although over half reside in wards VI, VII and VIII in the Eastern part of the city. Eligible recipients shall be required to select a primary care provider within ten (10) days of becoming eligible for the program. If they do not select a primary care provider, they shall be assigned to one.

### 12.3 Providers

Eligible providers can be prepaid plans, public health clinics owned or operated by the District, hospital outpatient clinics, certain community health centers, or physicians in private practice. To be eligible a provider must agree to comply with certain federal and District requirements, must meet the district's requirements for the practice of medicine and/or for the operation of a prepaid plan or health care facility and must be enrolled as a DC Medicaid provider. Payment for services shall be on a capitated basis for prepaid plans and fee-for-service for primary care physicians in private practice.

### 12.4 Program Overview

The DC Medicaid Managed Care program was developed to improve access to primary and preventive services while reducing the overall cost of care provided to DC Medicaid recipients. The reductions in cost result from changes in the behavior of patients who have the opportunity to develop stable and continuous relationships with primary care providers (PCP). The program will result in reduction in the inappropriate use of the emergency room for non-emergencies, avoidance of unnecessary inpatient admissions through more consistent primary and preventive care, and the elimination of "doctor-shopping."

The advantages for the recipients include:

- Access to consistent primary and preventive care
- 24 hour availability of a physician in case the recipient needs medical care
- The choice of a doctor or clinic
- An opportunity to develop a long-term relationship with a physician who will come to know the recipient's complete health history and will be responsible for coordinating his/her care
- Knowledge that his/her physician is responsible for coordinating his/her specialty and inpatient care needs
- **"HELPLINE"**, a recipient hotline for information and complaints.

## 12.0 DC Medicaid Managed Care

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The DC Medicaid Managed Care program seeks to optimize the investment in health care for DC Medicaid recipients which is particularly important in these times of fiscal austerity. Throughout the 1980's the number of DC Medicaid recipients remained constant but the cost of the program tripled. With increasing enrollment in the 1990's DC Medicaid Managed Care is one of the few ways of keeping costs under control without reducing services.

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## 13.0 VISION CARE SPECIFIC BILLING INSTRUCTIONS

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### 13.1 Definitions

The term “Ophthalmic Dispensing” means the design, verification and delivery to the intended wearer of lenses, frames and other specially fabricated optical devices upon prescription.

The term “prescription” means a written direction from a licensed ophthalmologist or optometrist for therapeutic or corrective lenses and consists of the refractive power and when necessary, the vertex distance, the cylinder axis and prism.

### 13.2 Eligibility to participate

Any optician or optometrist who is engaged in the retail dispensing of prescription eyewear in or from an established place of business, in area zoned for such purpose, with requisite occupancy, business or trade licenses and permits in full force and effect, may apply for participation in the DC Medicaid Program. Applications for participation will be considered only from those who are finally responsible and who have necessary equipment and personnel to provide the required services. The Department of Health (DOH) reserves the right to reject the application of any provider, if in the opinion of DOH, the firm does not all of the above qualifications.

1. Providers Eligible to prescribe

Ophthalmologists and Optometrists who have signed an Agreement of participation with the District Medicaid Program are authorized to prescribe eyewear for eligible District Medicaid recipients. Prescriptions from non-participating providers will require prior authorizations to be filled.

### 13.3 Medicaid Program Ethics

All participating opticians/optometrists shall keep foremost the welfare of the patient; shall seek to overcome any barriers to visual care, are so that no person lacks necessary services because of race, sex, age, or financial status; shall maintain offices in keeping with professional standards; and shall

## 13.0 Vision Care Specific Billing Instructions

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hold in professional confidence all information concerning a patient, using such data only for the benefit of the client.

Only first quality materials (frames and lenses) are to be used in the dispensing of optical products in the DC Medicaid Program, and the finished product must be meet the latest requirements and standards set forth in the American National Standards Institute (ANSI).

### 13.4 Scope of services

Ophthalmic dispensing services are provided to eligible recipients of the District Medicaid Program when prescribed by an optometrist or ophthalmologist who is licensed by the proper authority and dispensed by an optometrist or optician who has executed an agreement with the District Medicaid Program.

1. Restrictions and Limitations
  - a. Contact lenses and frames must be prior authorized by DHS
  - b. One pair of lenses and frames only every two (2) years unless prior authorized by DHS. Exceptions to this must be prior authorized, such as:
    - Recipients under twenty-one (21) years of age
    - Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter
  - c. Special glasses such as sunglasses and tints must be prior authorized and justified in writing by a=the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to un-tinted eyewear
  - d. An amount for frames costing more than the fee allowed by the District Medicaid Program will not be paid

### 13.5 Dispensing Procedures

In the event that a recipient requests a copy of the prescription once the prescriptions has been filled, the provider should write, type or stamp across the face of the prescription: *“This Prescription has already been filled”* and give

## 13.0 Vision Care Specific Billing Instructions

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the date on which and where the prescription was filled. DC Medicaid will reimburse for only one pair of eyeglasses per original prescription unless prior authorized.

To determine that the patient has not exceeded his quota of eyeglasses, to assure payment, call (202) 698-2000 for authorization prior to dispensing eyewear to follow the prior authorization procedure described in Section Five of this manual.

Effective August 1, 2003, the Department of Health no longer requires the submission of supporting documentation when submitting a vision care claim using Option I or Option II explained below. However, this supporting documentation, either an Ophthalmic Form or an Outside Laboratory invoice, must still be maintained by the provider.

In addition, examinations, frames, lens fabrications, and fittings are to be billed individually using the appropriate CPT and HCPCS values.

The department of Health authorizes either one or both of the following options for provision of ophthalmic services in the DC Medicaid Program:

1. Option I: Completed Eyewear Provided by Wholesaler
  - a. Prescription eyeglasses will be supplied by a wholesaler laboratory affiliated with the dispensing establishment or its practitioners through employment or any other financial connection) for an individual order paid for out-of-pocket by the optician or optometrist.
  - b. Practitioners choosing to use Optician I will be reimbursed at 70% of Medicare rates.
2. Option II: Fabricated of Eyewear on Premises
  - a. Providers, qualified by having special skills and equipment and choosing to participate using Option II, must supply semi-finished, uncut lens blanks of standard quality and durability, consistent with the latest ANSI standards, for fabrication (cutting, edging, polishing and fitting to frame) into prescription eyewear.
  - b. All lenses, frames and frame parts shall be guaranteed against defects in manufacture and assembly. The optometrist/optician

## 13.0 Vision Care Specific Billing Instructions

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dispensing the eyewear shall be responsible for any needed replacement or repairs that are due to defects in quality of material or workmanship.

- c. Frames used in the process of fabrication of eyeglasses shall be Selected from a current issue of the FRAMES index/catalog; will be referenced for verification on the Medicaid Laboratory Invoice for Ophthalmic Dispensing Service and paid for out-of-pocket by the optician or optometrist filling the prescription.
- d. Lenses used in the fabrication of eyeglasses will be paid for out-of-pocket by the provider and described fully on the invoice form. The description of lenses used from stock for the fabrication process and the SUMMARY OF COST, will be verified periodically by DOH.
- e. In addition to the dispensing fee, DOH will pay the established fabrication fee when the provider provides eyewear in accordance with option II. Providers qualified to use option II may also use option I.

### Dispensing Fee

The dispensing fee reimburse the provider of ophthalmic dispensing services for services which include, but may not be limited to, the following:

- a. Analysis of Prescription:
  - Translation of prescription specifies into character of lens required – as to perimeter and center thickness, weight size and method of grinding. Consideration of type of material - glass or plastic – and necessity for protective features.
  - Determinations of general type of frame for use with the lenses to be ordered and the intended use of the finished eyewear.

b. Measurement and Conformation:

- Measurement of patient's interpupillary distance (P.D.) for far and near and in case of high power lenses, measuring vertex distance of particular frame selected.
- If vertex distance of frames differs from refractive vertex distance in high power lenses, then recomputed lens power for correct effective power.
- In cases of multi-focal lenses, determine best type of lens and best size and positioning of segments for individual's needs.
- Assisting patient in selection of properly fitting frame with regard to the individual's facial characteristics or physiognomy and the intended use of the eyewear. At the same time, counseling as to cosmetic aspects.
- Measuring for correct eye size, bridge size and temple length and type.
- Making permanent record of all the above, with notations of deviation from normal shaping for better fitting purposes.

c. Ordering and Delivery.

- Preparing order for laboratory and establish record of such order with identifying name or symbol.
- Maintaining liaison with laboratories on time required to give reasonably accurate estimate to customer patient on time for delivery.
- Verifying completed eyewear as to accuracy of power and other specifics of the lenses, type and color of frames, security of fastenings, eye size and type and size of bridge and temples. Check surface quality of lenses for perfection of finish, freedom from waves, pits, grayness and scratches. Check lenses themselves for prescribed power, striae, bubbles or other interior defects.

## 13.0 Vision Care Specific Billing Instructions

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- Delivery of finished eyewear-This entails the fitting and adjusting of the completed glasses to the individual requirements of the patient in order to insure accuracy of performance and maximum comfort.
- Any instructions or warning pertaining to the use and care of the eyewear must be conveyed to the patient by the optician.
- A permanent record of the pertinent aspects of the foregoing must be made and maintained by the optician and kept available for the required period of time.
- Subsequent adjustments – Ordering or repairs as needed.

### 4. Prior Authorization

In order to receive reimbursement under the District Medicaid Program for those services requiring Prior Authorization the provider must complete a Prior Authorization Request/Approval Form (DHS 719A) and submit the to DHS for approval. Upon approval, DHS will supply the requesting provider with a seven (7) digit Prior Authorization Number. This must be entered on the claim form (HCFA 1500). DHS will not reimburse providers for those service requiring prior-authorization where the prior authorization/approval has not been obtained prior to the dispensing of eyewear.

## 13.6 Reimbursement

The participating optician/optometrist will accept as full payment for his ophthalmic dispensing services the fee schedule amounts in Section G of this manual. In some cases, an individual may qualify for both Medicaid and Medicare and sometimes for another health insurance plan (i.e., Vision Care Services, paid for under a union contract). Medicare or any other such insurance plan must be billed first. Title XIX will pay the approved patient liability, which may remain after third-party payments. The practitioner who dispenses the eyeglass is responsible for determining other source of coverage and should bill Title XIX only after all other sources have been exhausted.

## 13.0 Vision Care Specific Billing Instructions

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In order to be reimbursed for services rendered to District of Columbia Medicaid recipients, opticians and optometrists must bill examinations, frames, lense fabrications, and fittings individually using the appropriate CPT and HCPCS values. Reimbursement of ophthalmic services will be at 70% of Medicare rates.

### **Optician I**

Complete the HCFA 1500 as instructed.

Keep the original invoice for Outside Laboratory charges on file.

### **Optician II**

Complete the HCFA 1500 as instructed.

Keep the Medicaid Laboratory Invoice for Ophthalmic Dispensing Form on file.

## **13.7 Instructions for the Completion of the Prior Authorization Request/Approval Form**

When requesting prior authorization for ophthalmic dispensing services, the following blocks must be completed in order for the service to be reviewed and approved promptly:

### **INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST/APPROVAL FORM DHS 719A**

#### **BLOCK 1 PATIENT**

##### **A. RECIPIENT DC I.D. NUMBER**

Enter the recipient's Medicaid Identification Number exactly as it appears on the Medical Assistance Card.

##### **B. NAME (LAST, FIRST, MI) PRINT**

Print the recipient's name exactly as it appears on the Medical Assistance Card.

##### **C. ADDRESS**

Enter the recipient's address including the street, city, state and zip code.

##### **D. TELEPHONE NUMBER**

Enter the recipient's telephone number.

##### **E. DATE OF BIRTH**

Enter the recipient's date of birth.

**F. SEX**

Check the appropriate box on the form.

**BLOCK 2**

**REQUESTING PROVIDER**

**A. PROVIDER NUMBER**

Enter the requesting provider's 9-digit Medicaid identification number.

**B. NAME (LAST, FIRST, MI) PRINT**

Print the name of the practitioner who is requesting the service for the recipient.

**C. ADDRESS**

Enter the street address of the provider.

**D. CITY**

Enter the city where the street address is located.

**STATE**

Enter the state where the address is located.

**ZIP**

Enter the zip code of the address for the provider.

**E. TELEPHONE NUMBER**

Enter the telephone number of the provider.

### **BLOCK 3                    OTHER HEALTH INSURANCE COVERAGE**

Enter the name of the policy-holder, the plan name, the address, and the policy of any third party reported by the recipient or known by the provider to cover the services being requested.

### **BLOCK 4                    REQUESTED SERVICE**

Check the block “EYEWEAR” for requesting prior authorization for vision services or equipment.

### **BLOCK 5                    PATIENT LOCATION**

Check the block that appropriately describes the patient’s location. Enter the “Discharged Date” if the patient is still in a facility.

### **BLOCK 6                    DIAGNOSIS CODE**

Enter 799.9 or the appropriate ICD9-CM diagnosis code that relates to the eyewear or services being prior authorized.

### **BLOCK 7                    PROCEDURE CODE**

Enter the appropriate five-digit CPT-4 or District-assigned procedure codes that are being submitted for prior authorization.

### **BLOCK 8                    DESCRIPTION OF SERVICES, DURABLE MEDICAL EQUIPMENT OR SUPPLIES**

Describe the service or eyewear being submitted for prior authorization.

### **BLOCK 9                    TIME REQUIRED**

Enter the date that the eyewear will be dispensed or any other services provided.

## 13.0 Vision Care Specific Billing Instructions

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### **BLOCK 10                      FREQ. OR UNITS**

Enter the number of services required or the number of items required to provide for the patient's needs.

### **BLOCK 11                      ESTIMATED CHARGE (\$)**

Enter the estimated charge for the service or equipment.

### **BLOCK 12                      APPROVED AMOUNT (\$)**

This field will be completed by MAA.

### **BLOCK 13                      JUSTIFICATION**

Provide specific information justifying the utilization of the services and supplies requested in block 7 above. If additional information such as an operative report, x-ray or invoice are necessary to substantiate the request, write "see attachment" in the block.

### **BLOCK 14                      FOR DENTAL USE ONLY**

Reserved for dental provider use only.

### **BLOCK 15                      A.        SIGNATURE OF REQUESTING PROVIDER**

Signature of the provider requesting that the services be prior authorized.

### **B.        DATE**

Enter the date the form was signed.

### **13.0 Vision Care Specific Billing Instructions**

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The remainder of the form will be completed by Medical Assistance Administration who will provide the information to the provider that the services and eyewear have been approved or disapproved, the prior authorization number to be included on the claim form and the approved reimbursement amount to be paid.

## 13.0 Vision Care Specific Billing Instructions

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Insert sample Prior Authorization form here.

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## 13.8 Instructions for Completion of the HCFA 1500

The Health Care Financing Administration (HCFA) 1500 Health Insurance Claim Form is mandated for use by DHHS. Medicaid, Medicare, CHAMPUS and other health care providers requesting payment for services must use the HCFA 1500. To be reimbursed for services rendered on behalf of DC Medicaid recipients, providers of ophthalmic dispensing services must complete and file a HCFA 1500 claim form with ACS.

The following instructions outline specifically the use of the form when billing for ophthalmic dispensing services. A copy of this form follows the instructions for completion of the HCFA 1500 for ophthalmic dispensing services. These instructions may vary from the instructions included on the form to meet the specific requirements to reimburse providers for the services they have performed.

### INSTRUCTIONS FOR COMPLETION OF THE HCFA 1500 FOR VISION SERVICES PROVIDED

#### BLOCK 1 PROGRAM CHOICE

The provider must always check the block “Medicaid.”

#### BLOCK 1A INSURED’S ID NUMBER (FOR PROGRAM IN ITEM 1)

Enter in this block the recipient’s DC Medicaid Identification number. You must enter the complete 8-digit number excluding the leading zeroes.

Verify the recipient’s Medical Assistance Card to make certain that you have the recipient’s correct and complete DC Medicaid Identification number and that he is eligible for the month in which the services are being provided. You may call the EVS using the instructions included in Appendix D to verify eligibility.

## 13.0 Vision Care Specific Billing Instructions

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The vendor makes patient eligibility. Receipt of a prior authorization  
**DOES NOT VERIFY RECIPIENT ELIGIBILITY.**

When billing Medicaid, only the recipient's DC Medicaid Identification number should appear in this block.

### **BLOCK 2                      PATIENT'S NAME (Last Name, First Name, and Middle Initial)**

Enter the patient's last name, first name, and middle initial in this order. The name must be printed or typewritten exactly as it appears on the patient's Medical Assistance Card.

### **BLOCK 3                      PATIENT'S BIRTH DATE**

This block is optional. To complete you must enter the patient's date of birth using six digits (MM-DD-YY).

### **PATIENT'S SEX**

This information is required. To complete the block, place a check mark in the appropriate space.

3. PATIENT'S BIRTH DATE MM DD YY 09 03 29	SEX M <input type="checkbox"/> F <input type="checkbox"/>
---	--

### **BLOCK 4                      INSURED'S NAME (Last Name, First Name, and Middle Initial)**

Not required for processing.

### **BLOCK 5                      PATIENT'S ADDRESS (No., Street)**

Not required for processing.

**BLOCK 6                      PATIENT'S RELATIONSHIP TO INSURED**

Not required for processing.

**BLOCK 7                      INSURED'S ADDRESS (No., Street)**

Not required for processing.

**CITY**

Not required for processing.

**STATE**

Not required for processing.

**ZIP CODE**

Not required for processing.

**TELEPHONE (INCLUDE AREA CODE)**

Required for processing (if no phone – print NONE).

**BLOCK 8                      PATIENT STATUS**

Not required for processing.

**BLOCK 9                      OTHER INSURED'S NAME (Last Name, First Name, and  
Middle Initial)**

Not required for processing.

**BLOCK 9A                    OTHER INSURED'S POLICY OR GROUP NUMBER**

Enter the appropriate information as relevant. This information will only be completed if the recipient has more than one third-party resource that will make payment for the services.

**BLOCK 9B                    OTHER INSURED'S DATE OF BIRTH**

Not required for processing.

**SEX**

Not required for processing.

**BLOCK 9C                    EMPLOYER'S NAME OR SCHOOL NAME**

Enter data as relevant to the recipient. This information will only be completed if the recipient has more than one third-party resource that will make payment for the services.

**BLOCK 9D                    INSURANCE PLAN NAME OR PROGRAM NAME**

When billing the DC Medicaid Program on this form, information is entered in this block only if the recipient has more than one third-party resource that will make payment on the services provided.

Enter the name of the policyholder, the name of the carrier (Plan Name) or program (i.e., CHAMPUS), the address of the carrier or program and the number of the policy.

**BLOCK 10                    IS PATIENT'S CONDITION RELATED TO:**

**a.            EMPLOYMENT? (Current or Previous)**

## 13.0 Vision Care Specific Billing Instructions

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Check the appropriate space, yes or no.

**b. AUTO ACCIDENT?**

Check the appropriate space, yes or no. The state where the accident occurred should be entered as well

**c. OTHER ACCIDENT?**

Check the appropriate space, yes or no.

**d. RESERVED FOR LOCAL USE**

**BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER**

If the recipient informs you that he has a resource that will pay for the services provided this block must be completed. Examples of this coverage are Medicare, CHAMPUS, etc.

**BLOCK 11A INSURED'S DATE OF BIRTH**

Not required for processing.

**SEX**

Not required for processing.

**BLOCK 11B EMPLOYER'S NAME OR SCHOOL NAME**

Enter employer's name or school name if appropriate.

**BLOCK 11C INSURANCE PLAN NAME OR PROGRAM NAME**

### 13.0 Vision Care Specific Billing Instructions

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Enter plan name or program name as relevant to the service. If no additional third party has been identified either from the Medical Assistance Card or from interviewing the recipient, **NONE** should be entered in this field.

**BLOCK 11D IS THERE ANOTHER HEALTH BENEFIT PLAN?**

Check appropriate block.

**BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

Not required for processing.

**BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

Required for processing or signature on file can be used.

**BLOCK 14 DATE OF CURRENT:**

**ILLNESS (First symptom) OR  
INJURY (Accident) OR  
PREGNANCY (LMP)**

Nor required for processing.

**BLOCK 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE**

Not required for processing.

**BLOCK 16 DATES PATIENT UNABLE TO RETURN TO WORK IN CURRENT OCCUPATION**

Not required for processing.

**BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

Identify the name of the referring source.

**BLOCK 17A ID NUMBER OF REFERRING PHYSICIAN**

Enter the nine-digit provider number supplied by the managed care provider if the recipient is enrolled in the DC Medicaid Managed Care program.

**BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

If any of the services being billed on this invoice are related to hospitalization of the recipient, enter the patient's admit and discharge dates (MM-DD-YY).

If none of the services being billed on this invoice are related to hospitalization, leave blank.

**BLOCK 19 RESERVED FOR LOCAL USE**

No instructions are available for this field.

**BLOCK 20 OUTSIDE LAB**

Not required for processing.

**BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY  
(RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)**

Enter 799.9 for the diagnosis code.

**BLOCK 22 MEDICAID RESUBMISSION**

**CODE**

## 13.0 Vision Care Specific Billing Instructions

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Not required for processing.

### **ORIGINAL REF. NO.**

Not required for processing.

## **BLOCK 23**

### **PRIOR AUTHORIZATION NUMBER**

If prior authorization is required for any procedure billed on this invoice, obtain the prior authorization number from the appropriate source and enter the number in this block.

Only one procedure requiring prior authorization may be billed per invoice. However, other procedures not requiring prior authorization may be billed on the same invoice. If none of the procedures being billed on this invoice require prior authorization, leave this block blank.

### BLOCK 24A      DATE(S) OF SERVICE

Enter in this block the FROM and TO date of the service(s). The format of the date is MM-DD-YY. If the service was completed on the same day the TO date should be left blank. If the services were rendered on consecutive days, i.e., May 1, 2, 3, 4, the FROM date would be 05-01-94 and the TO date will be 05-04-94 and the units reflect the number of services provided. If you provided the same service to the same recipient on days that were not consecutive, each service date would require a separate line entry on the invoice.

### BLOCK 24B      PLACE OF SERVICE

For each line for which a service is being billed, you must enter the one code that best describes the location of the place of service.

#### Code    Description

11	PHYSICIAN'S OFFICE
12	RECIPIENT'S HOME
15	DAY TREATMENT
18	RESIDENTIAL TREATMENT
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM - HOSPITAL
24	AMBULATORY SURGICAL CENTER
31	NURSING FACILITY (SNF)
32	NURSING FACILITY
34	HOSPICE
41	AMBULANCE - LAND
42	AMBULANCE - AIR OR WATER
51	INPATIENT PSYCHIATRIC FACILITY

### 13.0 Vision Care Specific Billing Instructions

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<u>Code</u>	<u>Description</u>
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
61	REHABILITATION FACILITY61 COMPREHENSIVE INPATIENT
62	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
65	END STAGE RENAL DISEASE TREATMENT FACILITY
71	STATE OR LOCAL PUBLIC HEALTH CLINIC
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY

**BLOCK 24C      TYPE OF SERVICE**

Not required for processing.

**BLOCK 24D      PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual  
Circumstances)**

**CPT/HCPCS**

Enter in this block the the appropriate HCPCS procedure code that accurately describes the procedure, medical services, or supplies which are provided.

## 13.0 Vision Care Specific Billing Instructions

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### FULLY EXPLAIN PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED WHERE APPROPRIATE

#### BLOCK 24E DIAGNOSIS CODE

Enter the number of the diagnosis code entered in block 23 that relates to the service billed on each line.

#### BLOCK 24F \$ CHARGES

Enter your usual and customary charge for the procedure, service or supplies furnished. Do not subtract the co-payment. If the line entry reflects more than 1 unit of service or visit, make certain that the charges include all of the charges relevant to all of the services reflected by the line.

DATES OF SERVICE						Place of Service	Type of Service	PROCEDURES SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From	To							CPT/HCPCS	MODIFIER							
MM	DD	YY	MM	DD	YY											
08	02	94				12		Z0142		Swabs	1	7 00	2			

#### BLOCK 24G DAYS OR UNITS

Enter the frequency or units; whichever is appropriate for the line entry.

#### BLOCK 24H EPSDT Family Plan

Enter the required code, when appropriate:

- 1 - EPSDT
- 2 - Family Planning
- 3 - EPSDT and Family Planning

#### BLOCK 24I EMG

Not required for processing.

#### BLOCK 24J COB

Not required for processing.

**BLOCK 24K      RESERVED FOR LOCAL USE**

Not used at this time.

**BLOCK 25      FEDERAL TAX ID NUMBER**

**SSN**

Not required for processing.

**EIN**

Not required for processing.

**BLOCK 26      PATIENT'S ACCOUNT NO.**

This is an optional block for your use. If you assign a patient account number or identifying information for any reason, you may enter that information in this block. The information will appear on your RA and may aid you in reconciling your payments or professional productivity. The 14-character field may be any combination of numbers and letters.

**BLOCK 27      ACCEPT ASSIGNMENT? (For govt. claims, see back)**

Not required for processing.

**BLOCK 28      TOTAL CHARGE**

Enter the total of column 24F; total charges billed on this invoice.

## 13.0 Vision Care Specific Billing Instructions

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### **BLOCK 29**

#### **AMOUNT PAID**

Enter the total amount paid by other insurance for services being billed on this invoice.

NOTE: Blocks 28 and 29 should reflect totals. No calculations are to be made. The computer will automatically deduct amounts paid to correctly calculate the provider's payment.

### **BLOCK 30**

#### **BALANCE DUE**

Not required for processing.

### **BLOCK 31**

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

The authorized representative must sign the claim. Unsigned claims will not be processed and will be returned to the provider.

#### **DATE**

Enter the date you are completing the claim.

### **BLOCK 32**

#### **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)**

Not required for processing.

### **BLOCK 33**

#### **PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #**

Enter the name, address, and ZIP code of the entity to be paid for the service. Only the pay to entity is entered in block 33, whether or not this entity was the person actually providing the service. The individual actually providing the service must be identified in block 33.

## 13.0 Vision Care Specific Billing Instructions

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### **PIN #**

Enter the nine-digit Medicaid provider number.

### **GRP #**

Enter the 9-digit Medicaid provider number of the entity being paid for the service.

## 13.0 Vision Care Specific Billing Instructions

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Insert HCFA-1500 Claim form here.

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### 13.9 Instructions for Billing for Medicare Deductible and Coinsurance

In accordance with the District's State Plan, Medicare Part B deductibles and co-payments are limited to the State Plan rates and payment methodologies. For vision care services, DC Medicaid pays the deductible and co-insurance as calculated by Medicare.

Medicare must be billed first when billing for a Medicaid patient, who is also covered by Medicare. After Medicare processes the claim, submit a Medicare Crossover claim to Medicaid using the HCFA-1500 claim form.

**NOTE:** When billing for Medicare part B deductible and/or coinsurance, you must submit a HCFA-1500 claim form **with all required fields completed or the claim will be returned.** The Medicare EOMB must be attached, reflecting the amount of deductible/coinsurance. The procedure code information will allow ACS to determine Medicaid's payment obligation in accordance with the district's state plan.

### 13.10 Adjustment and Void Procedures

An Adjustment/Void claim is submitted when the original paid claim was filed or adjudicated incorrectly. Denied claims cannot be adjusted. All adjustment claims must be filed within one year of the original date of payment.

Adjustment/void claims for vision services are filed using the HCFA 1500 Claim Form. To indicate an adjustment or voided claim, the following information must be recorded in the top left-hand corner of the HCFA 1500 Claim Form:

<u>Code</u>	<u>Definition</u>
A	Adjustment
<b>-or-</b>	
V	Void
<b>-and-</b>	
TCN	Transaction control number

### 13.0 Vision Care Specific Billing Instructions

Using the HCFA 1500 Claim Form, the provider must indicate whether the claim is being **adjusted** by writing the letter “A” in the top left-hand corner of the form. If the claim is being **voided**, the provider must indicate such by writing the letter “V” in the top left-hand corner of the form. **The TCN is to be included at the top left-hand corner of both adjustments and voided claim forms.**

#### ADJUSTMENT REASON CODES

<u>Code</u>	<u>Long Description</u>
A5	ACCOMODATION CHARGE CORRECTION
A6	PATIENT PAYMENT AMOUNT CHANGED
A7	PROCEDURE OR SERVICE DATE CORRECTION
A8	CORRECTED DIAGNOIS CODE
A9	CORRECTED CHARGE AMOUNT
B0	UNIT, VISIT OR PROCEDURE CODE CORRECTION
B1	RECONSIDERATION OF ALLOWABLE AMOUNT
B2	CORRECTED ADMITTING, REFERRING OR PRESCRIBING PROVIDER NAME
B6	SERVICE NOT COVERED BY MEDICARE
B7	CORRECTED TOOTH CODE
B8	CORRECTED SITE CODE
B9	CORRECTED TRANSPORTATION DATA
C0	CORRECTED PAYMENT AMOUNT
C3	BILLING CLERK USED WRONG PROVIDER ID
C4	BILLING CLERK USED WRONG RECIPIENT ID
C9	SERVICE NOT COVERED BY PRIMARY CARRIER
D3	PARTIAL PAYMENT FROM LIABILITY INSURANCE
D4	PAYMENT CHANGE FOR RELATED CLAIM

### 13.0 Vision Care Specific Billing Instructions

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D8

OTHER INSURANCE IS AVAILABLE

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**APPENDIX A: ADDRESS AND TELEPHONE  
NUMBER DIRECTORY**

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**Appeal Notification – MAA copy**

Department of Health  
Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Attention: Appeal Unit

**Claims Appeal – Claims Over 6 Months Old Submission Information**

Department of Health  
Medical Assistance Administration  
Room 302  
2100 Martin Luther King, Jr. Avenue, SE  
Washington, DC 20020  
Attention: Timely Filing Claims Appeal

**Claim Status Information/Claims payment Information**

ACS  
District Medicaid Claims Processing Fiscal Agent  
P.O. Box 34734  
Washington, DC 20043  
Attention: Provider Inquiry Unit  
Telephone Number = 1-866-752-9233

## **Claim Submission Information**

### **Mail**

#### **For HCFA 1500s:**

ACS  
District Medicaid Claims Processing  
P.O. Box 34768  
Washington, DC 20043

#### **For UB92s:**

ACS  
District Medicaid Claims Processing  
P.O. Box 34693  
Washington, DC 20043

#### **For Dental and Pharmacy claims:**

ACS  
District Medicaid Claims Processing  
P.O. Box 34714  
Washington, DC 20043

#### **For Adjustments and Voids:**

ACS  
District Medicaid Claims Processing  
P.O. Box 34706  
Washington, DC 20043

#### **For Medicare Crossover claims:**

ACS  
District Medicaid Claims Processing  
P.O. Box 34770  
Washington, DC 20043

### **Telephone Inquiries:**

ACS Provider Inquiry Unit  
1-866-752-9233

## **CPT-4 Coding Information**

American Medical Association  
100 Enterprise Place  
P.O. Box 7046  
Dover, Delaware 19903-7046  
Attention: Order Department = 1-800-621-8335

## **ICD-9-CM Orders**

MEDICODE  
5225 Post Way  
Suite 500  
Salt Lake City, Utah 84116  
1-800-999-4600

## **District of Columbia Managed Care Enrollment Broker**

ACS State Healthcare (Formerly known as Concera) = (202) 639-4030

## **Durable Medical Equipment (DME)**

Request/Approval Information = (202) 698-2043  
Pharmacy Consultant Office = (202) 698-2043

## **Electronic Claims Submission/Electronic RA Information**

EDI (Electronic Data Interchange) Telephone Number: 1-866-775-8563

## **Eligibility Determination Information**

Income Maintenance Administration = (202) 724-5506

## **Eligibility Verification**

Eligibility Verification System (see Appendix D) = (202) 610-1847

## **General Program Information**

Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Telephone Number = (202) 698-2000

## **Medicaid Payment Schedule Information**

ACS, Inc.  
Provider Inquiry Unit  
P.O. Box 34743  
Washington, DC 200043  
Telephone Number: 1-866-752-9233

## **Nurse Aide Recertification**

Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Attention: Nurse Recertification  
(202) 698-2000

**Payment Schedule Information** (see Appendix B)

**Pharmacy Consultant**

Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Telephone Number = (202) 698-2043

**Prior Authorization Form Submission**

Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Attention: Prior Authorization Request

**Provider Enrollment Information**

ACS  
Provider Enrollment Unit  
P.O. Box 34761  
Washington, DC 20043-4761  
Telephone Number = 1-866-752-9231

**Recipient Eligibility HelpDesk**

EVS backup = 1-866-752-9233

### **Taxicab Voucher/Medical Necessity Form Submission**

Department of Health  
Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Attention: Transportation Department  
Telephone Number = (202) 698-2000

### **Taxicab Voucher Pick-Up**

Department of Health  
Medical Assistance Administration  
2100 Martin Luther King, Jr. Avenue, SE  
Suite 302  
Washington, DC 20020  
Telephone Number = (202) 698-2000

### **Third Party Liability**

Department of Health  
Medical Assistance Administration  
825 North Capitol Street, NE  
Washington, DC 20002  
Attention: Third Party Liability/Surveillance Utilization

Telephone:     Health Insurance – (202) 442-9048  
                      Casualty – (202) 442-9096 or (202) 442-9049  
                      States – (202) 442-9221  
                      SURS or General Information – (202) 442-9227

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**APPENDIX B: CURRENT CLAIM AND PAYMENT SCHEDULE**

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**ELECTRONIC CLAIMS SCHEDULE**

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Listed below is the Medicaid electronic claims schedule for fiscal year 2003. Electronic claims received by 12:00 noon on the submission dates indicated below will be included in that payment cycle. Those received after that time will be included in the next payment cycle.

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
10-01-2002	Thursday, 09-26-2002	09-28-2002
10-15-2002	Thursday, 10-10-2002	10-12-2002
11-01-2002	Thursday, 10-31-2002	11-02-2002
11-15-2002	Thursday, 11-14-2002	11-16-2002
12-01-2002	Thursday, 11-28-2002	11-30-2002
12-15-2002	Thursday, 12-12-2002	12-14-2002
01-01-2003	Thursday, 12-26-2002	12-28-2003
01-15-2003	Thursday, 01-09-2003	01-11-2003
02-01-2003	Thursday, 01-30-2003	02-01-2003
02-15-2003	Thursday, 02-13-2003	02-15-2003
03-01-2003	Thursday, 02-27-2003	03-01-2003
03-15-2003	Thursday, 03-13-2003	03-15-2003
04-01-2003	Thursday, 03-27-2003	03-29-2003
04-15-2003	Thursday, 04-10-2003	04-12-2003

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
05-01-2003	Thursday, 05-01-2003	05-03-2003
05-15-2003	Thursday, 05-15-2003	05-17-2003
06-01-2003	Thursday, 05-29-2003	05-31-2003
06-15-2003	Thursday, 06-12-2003	06-14-2003
07-01-2003	Thursday, 06-26-2003	06-28-2003
07-15-2003	Thursday, 07-10-2003	07-12-2003
08-01-2003	Thursday, 07-31-2003	08-02-2003
08-15-2003	Thursday, 08-14-2003	08-16-2003
09-01-2003	Thursday, 08-28-2003	08-30-2003
09-15-2003	Thursday, 09-11-2003	09-13-2003
10-01-2003	Thursday, 09-25-2003	09-27-2003

## MEDICAID HARDCOPY CLAIMS SCHEDULE

Listed below is the Medicaid schedule for the submission of hardcopy (paper) claims for fiscal year 2003. Claims received by 12:00 noon on the submission dates indicated below will be included in that payment cycle. Those received after that time will be included in the next payment cycle.

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
10-01-2002	Thursday, 09-19-2002	09-28-2002
10-15-2002	Thursday, 10-03-2002	10-12-2002
11-01-2002	Thursday, 10-24-2002	11-02-2002
11-15-2002	Thursday, 11-07-2002	11-16-2002
12-01-2002	Thursday, 11-21-2002	11-30-2002
12-15-2002	Thursday, 12-05-2002	12-14-2002
01-01-2003	Thursday, 12-19-2002	12-28-2003
01-15-2003	Thursday, 01-02-2003	01-11-2003
02-01-2003	Thursday, 01-23-2003	02-01-2003
02-15-2003	Thursday, 02-06-2003	02-15-2003
03-01-2003	Thursday, 02-20-2003	03-01-2003
03-15-2003	Thursday, 03-06-2003	03-15-2003
04-01-2003	Thursday, 03-20-2003	03-29-2003
04-15-2003	Thursday, 04-03-2003	04-12-2003
05-01-2003	Thursday, 04-24-2003	05-03-2003
05-15-2003	Thursday, 05-08-2003	05-17-2003
06-01-2003	Thursday, 05-22-2003	05-31-2003
06-15-2003	Thursday, 06-05-2003	06-14-2003

<u>Date of Cycle</u>	<u>Submission Date</u>	<u>Run Date</u>
07-01-2003	Thursday, 06-19-2003	06-28-2003
07-15-2003	Thursday, 07-03-2003	07-12-2003
08-01-2003	Thursday, 07-24-2003	08-02-2003
08-15-2003	Thursday, 08-07-2003	08-16-2003
09-01-2003	Thursday, 08-21-2003	08-30-2003
09-15-2003	Thursday, 09-04-2003	09-13-2003
10-01-2003	Thursday, 09-18-2003	09-27-2003

## **MEDICAID PAYMENT SCHEDULE**

Listed below is the payment schedule for fiscal year 2003.

<b><u>Date of Cycle</u></b>	<b><u>Run Date</u></b>
10-01-2002	09-28-2002
10-15-2002	10-12-2002
11-01-2002	11-02-2002
11-15-2002	11-16-2002
12-01-2002	11-30-2002
12-15-2002	12-14-2002
01-01-2003	12-28-2003
01-15-2003	01-11-2003
02-01-2003	02-01-2003
02-15-2003	02-15-2003
03-01-2003	03-01-2003
03-15-2003	03-15-2003
04-01-2003	03-29-2003
04-15-2003	04-12-2003
05-01-2003	05-03-2003
05-15-2003	05-17-2003
06-01-2003	05-31-2003
06-15-2003	06-14-2003

**Date of Cycle****Run Date**

07-01-2003

06-28-2003

07-15-2003

07-12-2003

08-01-2003

08-02-2003

08-15-2003

08-16-2003

09-01-2003

08-30-2003

09-15-2003

09-13-2003

10-01-2003

09-27-2003

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## **APPENDIX C: EPSDT VACCINE BILLING CODES**

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Refer to attached transmittal for procedure codes to be utilized for billing DC Medicaid for vaccines.

INSERT SAMPLE TRANSMITTAL HERE

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## **APPENDIX D: EVS INSTRUCTIONS**

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It is the responsibility of the provider to ensure the patient is eligible for Medicaid.

To access the District of Columbia Government Medicaid Recipient **Eligibility Verification System** (EVS), dial the following telephone number:

**(202) 610-1847**

After dialing the number, EVS will answer the call and respond with:

**DC MEDICAID ELIGIBILITY SYSTEM**

The system will then prompt you with:

**PLEASE ENTER YOUR PROVIDER NUMBER**

You should respond by using a touch-tone phone to enter your nine-digit provider identification number.

If no data is entered within the specified time period, or if insufficient data is entered, the system will respond with:

**INELIGIBLE PROVIDER NUMBER**

**PLEASE REPEAT YOUR ENTRY**

You will be given three (3) opportunities to enter a valid provider number. After three (3) invalid provider numbers have been entered, the call will be disconnected. After you have verified your provider number, you should redial EVS to verify the information.

Once a valid provider number has been entered, you will be prompted with:

## **PLEASE ENTER YOUR RECIPIENT NUMBER**

The recipient identification number, an eight (8) digit code, should be entered exactly as it appears on the Medical Assistance Card. After entering the eighth digit, the system will respond:

## **PLEASE ENTER THE LAST NAME CODE**

Respond by entering the numeric representation of the first letter of the recipient's last name. The numeric sequence for the last name is generated in the following manner:

1. Depress the key containing the desired letter. For example, for a last name beginning with an A, the first digit of the key will be 2.
2. Press a 1, 2, or 3 depending upon the letter's position on the telephone button. For example, the letter A is the first character on button 2; therefore, the second digit of the key is 1. The entire key for A is 21. Similarly, B is 22 and C is 23. Since the characters Q and Z do not appear on the keypad, the sequences of 11 for Q, and 12 for Z should be used to enter these alphabetic characters.

The following table may be used to enter the name keys for EVS:

<b>A</b>	<b>21</b>
<b>B</b>	<b>22</b>
<b>C</b>	<b>23</b>
<b>D</b>	<b>31</b>

<b>J</b>	<b>51</b>
<b>K</b>	<b>52</b>
<b>L</b>	<b>53</b>
<b>M</b>	<b>61</b>

<b>S</b>	<b>73</b>
<b>T</b>	<b>81</b>
<b>U</b>	<b>82</b>
<b>V</b>	<b>83</b>

<b>E</b>	<b>32</b>
<b>F</b>	<b>33</b>
<b>G</b>	<b>41</b>
<b>H</b>	<b>42</b>
<b>I</b>	<b>43</b>

<b>N</b>	<b>62</b>
<b>O</b>	<b>63</b>
<b>P</b>	<b>71</b>
<b>Q</b>	<b>11</b>
<b>R</b>	<b>72</b>

<b>W</b>	<b>91</b>
<b>X</b>	<b>92</b>
<b>Y</b>	<b>93</b>
<b>Z</b>	<b>12</b>

If you make an error entering the last name codes, the system will pre-prompt with:

**INVALID RECIPIENT NUMBER**

**PLEASE REPEAT YOUR ENTRY**

At this point, you should re-enter the Recipient Number. The system will prompt you as it did during the initial attempt to verify the data.

Upon successfully entering the last name code, the system will prompt you with the following:

**PLEASE ENTER THE FIRST NAME CODE**

You should respond by entering the numeric representation of the first letter of the first name. The algorithm used to enter the first name code is the same as for the last name code. Please refer to the table above for assistance translating the name to a numeric representation.

If an error is made when entering the first name, the system will re-prompt with:

**INVALID RECIPIENT NUMBER**

**PLEASE REPEAT YOUR ENTRY**

Now you must enter the recipient number and follow the process for entering the last name and first name. The system will prompt you through the process as it did during the first entry.

You will be given three (3) opportunities to enter a valid recipient identification number with valid name codes. After entering three invalid recipient identification numbers with name codes, the call will be disconnected.

If the recipient number exists in the database and matches the name code entered, the system will respond with one of the following messages based on the information available for the recipient:

- Eligible Medicaid HMO, including the name and telephone number of the Managed Care Organization
- Eligible Medicaid and Medicare
- Eligible Medicaid and Third Party
- Eligible Medicaid
- Eligible Medicaid Restricted
- Eligible for Pregnancy Related Services Only

The system will then prompt you with:

## **ENTER NEXT RECIPIENT**

To verify another recipient, begin by entering the recipient number and follow the instructions above. Otherwise press asterisk (\*) to end the call. A maximum of five (5) recipients can be verified during a single call.

If you encounter problems accessing the EVS system, call the Recipient Eligibility Help Desk (EVS backup) at 1-866-752-9233.

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**APPENDIX E:        MAA Department of Human Services Medicaid Laboratory  
Invoice for Ophthalmic Dispensing, Option II Form**

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Complete the following MAA Department of Human Services Medicaid Laboratory Invoice for Ophthalmic Dispensing, Option II form and attach to the HCFA 1500.

Insert MAA Department of Human Services Medicaid Laboratory Invoice for Ophthalmic Dispensing, Option II Form here.

Delete this appendix.